

# Challenging Pregnancy Discrimination in Drug Treatment: Does the ADAMHA Reorganization Act Provide an Answer?

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Why should anyone have to be like white men to get what they have, given that white men do not have to be like anyone except each other to have it?<sup>1</sup>

## INTRODUCTION

Cleo Washington was seven months pregnant with her second child when she was forced to leave drug treatment; the city had cut the program from its budget. This was Washington's third attempt to seek treatment during her pregnancy. Initially, she tried acupuncture, but left the program because she was afraid that the needles might be infected and was offended by the drug dealers gathering just outside the door. Next, she attended a coed program, which placed men, women, and children in the same room during therapy. Her city caseworker then referred her to a special program for mothers and pregnant women. Three weeks later, it closed. Frustrated, Washington decided not to seek out a fourth program although she knew state authorities might place her children in foster care. "I'll just stay home," she said, "I don't want the aggravation of starting over."<sup>2</sup>

The story of Cleo Washington is not unique. Across the country, pregnant women face major obstacles when seeking treatment for their drug dependence. Many are denied access to programs simply because they are pregnant.<sup>3</sup> Some of those who do find treatment must resort to clinics that do not sufficiently meet their needs.<sup>4</sup>

As one response to this crisis,<sup>5</sup> Congress recently passed the ADAMHA

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1. Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1287 (1991).

2. Anemona Hartocollis, *Doors Closing For Young Mom Fighting Drugs*, NEWSDAY, June 28, 1991, at 34. These New York City budget cuts were projected to result in the exclusion of 9,200 drug addicts, mostly women, from treatment. See *id.*

3. See *infra* notes 22-29 and accompanying text.

4. See *infra* notes 45-67 and accompanying text.

5. For a discussion of constitutional avenues for challenging pregnancy discrimination in drug treatment programs, see generally Megan R. Golden, Note, *When Pregnancy Discrimination is Gender*

(Alcohol, Drug Abuse, and Mental Health Administration) Reorganization Act.<sup>6</sup> This legislation, which restructures programs first created by the Omnibus Budget Reconciliation Act of 1981,<sup>7</sup> expands block grants provided to states for drug treatment programs<sup>8</sup> and targets a portion of this funding for addressing the particular needs of pregnant drug-addicted women. ADAMHA programs focusing on pregnant drug-addicted women include specific grants for residential and outpatient treatment of pregnant and postpartum women<sup>9</sup> and increased set-asides for pregnant women.<sup>10</sup> Moreover, ADAMHA requires that states give preference to pregnant women in admission to substance abuse treatment facilities and, where admission is not available, that states provide interim services within forty-eight hours.<sup>11</sup> The Act also underwrites the federal share of costs of home visits to pregnant women at risk of delivering infants with "health or developmental complication[s]"<sup>12</sup> and mandates research regarding medications to treat drug-addicted pregnant women safely.<sup>13</sup>

In addition to initiating the affirmative steps discussed above, Congress also inserted a revised provision explicitly prohibiting pregnancy discrimination by recipients of federal funds.<sup>14</sup> The addition of this pregnancy discrimination

*Discrimination: The Constitutionality of Excluding Pregnant Women From Drug Treatment Programs*, 66 N.Y.U. L. REV. 1832 (1991) (arguing that pregnancy discrimination in drug-treatment programs is prohibited directly under the Constitution). State and municipal laws, such as public accommodation statutes, may also provide relief. *Elaine W. v. Joint Diseases N. Gen. Hosp.*, 613 N.E.2d 523 (N.Y. 1993) (challenge to the exclusion of pregnant women from drug-treatment programs under New York public accommodations law).

6. Pub. L. No. 102-321, 106 Stat. 323 (codified as amended in scattered sections of 42 U.S.C.A. §§ 201-300 (West Supp. 1993)). Because alcoholism among pregnant women raises somewhat different concerns, including detoxification safety, *see* 1 COMM. FOR THE SUBSTANCE ABUSE COVERAGE STUDY, DIV. OF HEALTH CARE SERVS., INST. OF MED., TREATING DRUG PROBLEMS 234 (Dean R. Gerstein & Henrick J. Harwood eds., 1990) [hereinafter TREATING DRUG PROBLEMS], and does not bring with it the same social stigma as the use of illegal substances, this article will only address the statute's effect on drug-addicted women. The statute, however, also addresses treatment for alcohol abuse.

7. 95 Stat. 357 (1981).

8. Most public programs receive ADAMHA funding. Telephone Interview with Ripley Forbes, Senior Staff Associate, House Subcommittee on Health and the Environment (Jan. 5, 1993).

9. *See* 42 U.S.C.A. § 290bb-1,2 (West Supp. 1993).

10. *See* 42 U.S.C.A. § 300x-22 (West Supp. 1993).

11. *See* 42 U.S.C.A. § 300x-27 (West Supp. 1993). If a particular program can not accommodate a pregnant woman, the burden shifts to the state to find an alternative location or to provide her with the interim services. *Id.* Interim services are defined as "services for reducing the adverse health effects of [substance] abuse, for promoting the health of the individual, and for reducing the risk of transmission of disease, which services are provided until the individual is admitted to such a program." 42 U.S.C.A. § 300x-64 (West Supp. 1993).

12. 42 U.S.C.A. § 280c-6 (West Supp. 1993). The federal share of costs "may not exceed 90 percent." *Id.*

13. *See* 42 U.S.C.A. § 285o-4 (West Supp. 1993).

14. "No person shall on the ground of sex (including, in the case of a woman, on the ground that the woman is pregnant) . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available" under the block grant provisions. 42 U.S.C.A. § 300x-57(a)(2) (West Supp. 1993). The former version of the provision proscribed sex discrimination but did not include pregnancy within that definition. 42 U.S.C. § 300x-7(a)(2) (1988). This change is particularly important in light of the Supreme Court's holding in *Geduldig v. Aiello*, 417 U.S. 484 (1974), that pregnancy discrimination is not sex discrimination under the Equal Protection Clause of the Fourteenth Amendment. *Id.* at 496 n.20 (explaining that an insurance

clause is vital; it offers more immediate and more expansive relief than the new programs created by ADAMHA.<sup>15</sup> Under this provision, pregnant women can gain access to already-existing drug treatment programs, rather than awaiting the establishment of new ones. Moreover, the pregnancy discrimination clause expands the number of women who will benefit from the statute. While the new programs created by the statute will help only a limited number of women, due both to the finite nature of new funding and to the lag time between the provision of grants and the creation of new treatment options, the nondiscrimination provision offers access to treatment slots in *all* programs receiving ADAMHA funding.

This article will explore the parameters of the ADAMHA nondiscrimination provision and the ways in which it responds to the crisis of drug addiction among pregnant women.<sup>16</sup> Part I will examine the background against which Congress passed the new law, focusing on the extent of drug dependence among pregnant women, the inaccessibility of appropriate treatment for both women in general and pregnant women in particular, and the potential harms to pregnant women and their fetuses due to continued drug use. Part II will explore punitive and coercive responses by state and local governments to the problem of drug dependence among pregnant women, examine the costs of such approaches, and argue that the need for such drastic measures would be reduced by expanding treatment options. Part III will look at whether the new ADAMHA nondiscrimination provision can be privately enforced. More specifically, it will undertake the following inquiries: Can a plaintiff bring a private suit directly under the statute or as a § 1983 action? Who are the potential defendants? What are the available remedies? Part IV will examine the substantive standards that courts should apply in interpreting the ADAMHA provision, including the availability of affirmative defenses. Because no case has yet been adjudicated under ADAMHA's nondiscrimination provision, this article will use relevant statutory and common law to propose a paradigm for approaching such cases in the future.

## I. THE CONTOURS OF THE PROBLEM

Drug use among pregnant women has reached significant proportions, yet many pregnant women do not receive the drug treatment they need. This

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plan that excluded pregnancy benefits did not constitute sex discrimination because it merely "divides potential recipients into two groups—pregnant women and nonpregnant persons"). Thus, when Congress intends to alter that definition for the purposes of a statute, it must do so explicitly in order to leave no room for debate. *See, e.g.*, 42 U.S.C. § 2000e(k) (1988) (defining sex discrimination to include pregnancy discrimination under Title VII of the Civil Rights Act of 1964).

15. The progress effectuated by these new programs should not be underestimated. While they are important steps toward meeting the particular needs of pregnant women, their beneficial impact will emerge on a long-term basis.

16. This article focuses on how ADAMHA's nondiscrimination clause would be utilized in litigation. The possibility for judicial enforcement, however, also provides a tool for applying pressure in the political and regulatory arenas.

problem is part of a more general marginalization of the needs of women addicts. As a result, many pregnant women face continued addiction—wreaking havoc on their health and the well-being of their fetuses. This picture provides the backdrop against which Congress passed the ADAMHA Reorganization Act.

*A. The Extent of Drug Use Among Pregnant Women and the Inaccessibility of Treatment*

Nationwide, pregnant drug-addicted<sup>17</sup> women give birth to 375,000 babies each year.<sup>18</sup> Yet, a survey of nineteen hospitals in fifteen cities indicated that in two-thirds of the cases, hospitals could not refer drug-addicted pregnant women for treatment.<sup>19</sup> Estimates of the number of drug-exposed infants born annually in New York City range between 7000<sup>20</sup> and 10,000.<sup>21</sup> A recent survey, however, showed that 54% of the outpatient treatment programs in New York City categorically excluded pregnant women, 67% did not provide services to pregnant women on Medicaid, and 87% denied treatment to pregnant women on Medicaid who used crack.<sup>22</sup> Further, twenty-two of the twenty-six state-funded residential programs in New York City do not admit pregnant women.<sup>23</sup>

Pregnant drug-addicted women across the country face similar obstacles in seeking treatment. In Philadelphia, for example, one study showed that 16.3% of all babies born in Philadelphia that year had been exposed to cocaine.<sup>24</sup> Yet, a recent survey of area programs revealed that fourteen clinics, most of which receive public funding, categorically excluded pregnant women, and six additional programs placed severe restrictions<sup>25</sup> on pregnant women that effectively barred most of them.<sup>26</sup> In Washington D.C.,

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17. The medical community defines addiction as "a biological, social, and psychological response to a drug, most usefully compared to a chronic illness in which relapse can be anticipated." Wendy Chavkin, *Workshop on Public Policy Considerations*, 67 BULL. N.Y. ACAD. MED. 301, 301 (1991).

18. See Tamar Lewin, *Drug Use in Pregnancy: New Issue for the Courts*, N.Y. TIMES, Feb. 5, 1990, at A14.

19. Michelle Harrison, *Drug Addiction in Pregnancy: The Interface of Science, Emotion, and Social Policy*, 8 J. SUBSTANCE ABUSE TREATMENT 261, 264 (1991).

20. Sarah L. Krauss, *Pregnant Cocaine Addicts Facing Harsher Sentences in the Courts*, N.Y. L.J., May 1, 1992, at S-10.

21. Hartocollis, *supra* note 2, at 34.

22. Wendy Chavkin, *Drug Addiction and Pregnancy: Policy Crossroads*, 80 AM. J. PUB. HEALTH 483, 485 (1990).

23. Clara Hemphill, *Programs for Addicts Stalled*, NEWSDAY, Oct. 29, 1990, at 8. In 1989, New York City attempted to implement a five-year plan to create 21,000 treatment slots, many of which would be for pregnant and postpartum women. See Carol Polsky, *Crack in Family Portrait*, NEWSDAY, Nov. 5, 1989, at 6. This plan was slowed down, however, by bureaucratic delays and internal local government disputes. See Hemphill, *supra*, at 8.

24. David Zucchino, *Women's Group Seeks Probe at Health Centers*, PHILA. INQUIRER, Oct. 28, 1992, at B2.

25. *Id.* The restrictions generally relate to the stage of a woman's pregnancy or to her medical insurance.

26. See *id.* The Philadelphia Human Relations Commission is investigating these allegations. This is

approximately 2000 drug-exposed babies are born each year, but as of 1990 there were no inpatient treatment programs that focused on the needs of pregnant women.<sup>27</sup> On the opposite coast, an estimated 80,000 drug-exposed infants are born annually in California,<sup>28</sup> yet treatment options do not meet the existing need.<sup>29</sup>

No matter where they live, pregnant women are often turned away from treatment programs simply because they are pregnant.<sup>30</sup> Timely admittance to drug treatment is especially vital for pregnant women because the fetus is most vulnerable to damage from drug use during the first trimester.<sup>31</sup> The need for treatment, however, remains urgent throughout pregnancy.<sup>32</sup>

The major justifications for excluding pregnant women offered by drug treatment programs are based on medical concerns. Programs assert that they do not have the resources safely to meet the special needs of pregnant

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the second complaint of such discrimination filed in the country. In New York, the ACLU is challenging the exclusion of pregnant women from two hospital-based programs. *See* Plaintiffs' Complaint at 1, *Elaine W. v. Joint Diseases N. Gen. Hosp.*, (N.Y. Sup. Ct. 1991) (No. 90-6230) [hereinafter Plaintiffs' Complaint].

27. Elsa Walsh, *D.C. Report Blasts Focus of Drug War*, WASH. POST, May 10, 1990, at B1, B7.

28. Philip Hager, *Case Sparks Debate Over Fetal Murder*, L.A. TIMES, June 17, 1992, at B1.

29. *See id.*

30. *See* Marty Jessup, *The Treatment of Perinatal Addiction: Identification, Intervention, and Advocacy*, 152 W. J. MED. 553 (1990). Advocates for these women assert that there is no justification for such blanket exclusions on the basis of pregnancy. One advocate explained,

There is no medical reason why they should not be in treatment with others. There is a phobia of pregnancy, an unnecessary fear of pregnancy. . . . No one is asking them to provide any more medical care for a pregnant woman than they would for hepatitis, heart disease, or any other common ailment. . . . Their job is to treat the substance abuse, and there is a full network of prenatal-care providers . . . who can provide prenatal care.

Marianne Costantinou & Robin Palley, *No Rehab for Pregnant Addicts?*, PHILA. DAILY NEWS, Oct. 27, 1992, at 11 (quoting Carol Tracy, Executive Director of the Women's Law Project).

31. *See* Jessup, *supra* note 30, at 554.

32. *See* Chavkin, *supra* note 22, at 483. One series of studies showed that "up to 25 percent of all pregnant women receiving medical assistance Health Pass who come to the University of Pennsylvania have used cocaine within 24-48 hours of delivery." *Hearing Before Philadelphia Comm'n on Human Relations* 139 (Jan. 10, 1994) (statement of Dr. Arnold Cohen, Director of Maternal Health, University of Pennsylvania) [hereinafter Statement of Dr. Arnold Cohen] (on file with the *Yale Journal of Law and Feminism*). While not all of these women would seek treatment if available, some would enter programs. The shortage of treatment slots for pregnant women discourages those women who otherwise would seek help. *See supra* note 2 and accompanying text.

women.<sup>33</sup> They are also concerned with liability for harming the fetus.<sup>34</sup> These justifications, however, are not supported by the facts and the law.<sup>35</sup>

### B. *The Broader Context: The Shortage of Appropriate Treatment for Women*

The lack of access to treatment for pregnant women is best understood as part of the general scarcity of appropriate treatment programs for women.<sup>36</sup> This problem can be traced to two main causes: the shortage of drug treatment programs that accept women and the inability of programs that do accept women to address their spectrum of needs.<sup>37</sup> Historically, the drug treatment community has neglected the needs of women addicts.<sup>38</sup> Many of the programs were developed to treat men only.<sup>39</sup> "Conservative estimates indicate that women represent 33% of those in need of treatment, yet a national survey indicates that 80% of the treatment resources are used by men."<sup>40</sup>

For women who gain admission to drug treatment programs, there still is no guarantee that their needs will be adequately met. Because the drug treatment system was initially created for men, rehabilitation approaches often do not take into account women's different social roles. Furthermore, drug treatment programs often do not provide medical and social services, which

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33. See discussion *infra* part IV.B.1. Historically, distinguishing women from men on the basis of biological differences has led to the legal, social, and economic subordination of women. See, e.g., *Goesaert v. Cleary*, 335 U.S. 464 (1948) (upholding statute prohibiting women from working as bartenders unless supervised by their husbands or fathers), *overruled by* *Craig v. Boren*, 429 U.S. 190, 210 n.23 (1976); *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937) (upholding minimum wage statute only for women); *Radice v. New York*, 264 U.S. 292 (1924) (upholding statute prohibiting women from working in restaurants in large cities at night); *Muller v. Oregon*, 208 U.S. 412, 421 (1908) (justifying maximum hour laws for women only on the grounds that "woman's physical structure and the performance of maternal functions place her at a disadvantage in the struggle for subsistence"); *Bradwell v. Illinois*, 83 U.S. 130, 141 (1872) (Bradley, J., concurring) ("The natural and proper timidity and delicacy which belongs to the female sex evidently unfits it for many of the occupations of civil life. . . . The paramount destiny and mission of women are to fulfill the noble and benign offices of wife and mother."), *overruled by* *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2831 (1992). For a more recent example, see *Dothard v. Rawlinson*, 433 U.S. 321, 332-37 (1977) (upholding state regulation that prevents women prison guards from serving in "contact" positions due to the likelihood that inmates would sexually assault them because they are women).

34. See discussion *infra* part IV.B.2.

35. For a discussion on why these defenses fail, see discussion *infra* part IV.B.

36. It is important to note that this problem is itself part of a larger shortage of drug treatment slots nationwide. See, e.g., Celestine Bohlen, *Dinkins Urges More Financing of Drug Centers*, N.Y. TIMES, Sept. 26, 1989, at B2; John J. Goldman, *Neglected Weapon in Drug War*, L.A. TIMES, Apr. 6, 1990, at A1; Julie Mason, *Dispute Threatens Closure of Drug-Treatment Center*, HOUS. CHRON., Sept. 26, 1992, at A1. In the context of this shortage, however, pregnant women are disproportionately affected. For example, currently in South Carolina there are no drug treatment programs that accept pregnant women. See Philip J. Hiltz, *Hospital is Accused of Illegal Drug Testing*, N.Y. TIMES, Jan. 21, 1994, at A12. On a nationwide basis, Medicaid coverage does not adequately cover drug treatment for pregnant women. See *Law and Policy Affecting Addicted Women and Their Children: Hearings Before the House Select Comm. on Children, Youth and Families*, 101st Cong., 1st Sess. 105-110 (1990) (Prepared Statement of David Gates, Staff Attorney, National Health Law Program).

37. See discussion *infra* part I.B.1-2.

38. See Chavkin, *supra* note 22, at 485.

39. *Id.*

40. Carol E. Tracy & Harriet C. Williams, *Social Consequences of Substance Abuse Among Pregnant and Parenting Women*, 20 PEDIATRIC ANNALS 548, 550 (1991).

are an essential part of treating drug-addicted pregnant women. These failings have a particularly detrimental effect on pregnant women, because their needs are greater than nonpregnant women in both of these respects.

The neglect or omission of women's needs from drug treatment programs may be attributed to a number of factors. Because programs were initially created by and for men, they were run from a male-centered perspective. As a result, the drug treatment community felt that accommodation of women's needs would involve the provision of additional, i.e. "extra," systems and services. Where women's needs are seen as supplemental (rather than as part of the baseline for measuring sufficient services), efforts to address them are mired in the "debate about whether [women] are getting more or not enough."<sup>41</sup> This, in turn, allows women's concerns to be dismissed, or delegitimized, as requests for "perks."<sup>42</sup>

Of course, our society and the drug treatment community marginalize the treatment needs of pregnant drug-addicted women in ways that are not applicable to all of these women. Our society stigmatizes pregnant drug addicts and often blames them for their addiction and for the harm they cause their fetuses.<sup>43</sup> This stigma is based, in part, on the belief that certain women, due to their race and class, are not worthy of bearing children and becoming mothers.<sup>44</sup> Thus, the drug treatment community often sees pregnant addicts as unworthy of accommodation in drug treatment programs. These societal judgments and instances of neglect, however, should be rejected and the biases in the drug treatment delivery should be addressed in order to create a more equitable system.

### 1. *Gender Issues in Drug Treatment Approaches*

Because substance abuse programs were initially developed to treat men, many of the approaches currently employed do not target women's needs.<sup>45</sup>

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41. Wendy W. Williams, *Equality's Riddle: Pregnancy and the Equal Treatment/Special Treatment Debate*, 13 N.Y.U. REV. L. & SOC. CHANGE 325, 367 (1984-85).

42. A discussion of the particular needs of women—and of pregnant women—implicates a much larger debate about how social and biological distinctions should be addressed by the law. "When we identify one thing as like the others, we are not merely classifying the world; we are investing particular classifications with consequences . . . [W]e use our language to exclude, to distinguish—to discriminate." MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW* 3 (1990). For a range of views on how pregnancy should be viewed in social, political, and legal contexts, see generally CATHARINE A. MACKINNON, *FEMINISM UNMODIFIED* 32-45 (1987) (advocating paradigm for law of sex discrimination which focuses on eliminating dominance); Ann Scales, *Towards a Feminist Jurisprudence*, 56 IND. L.J. 375 (1981) (advocating a "difference" model); Williams, *supra* note 41 (endorsing an "equal treatment" approach that incorporates both male and female needs in an "androgynous" prototype). These analyses may help inform the transformation of drug treatment programs to address the needs of pregnant women.

43. See *infra* part II.A. (discussing the phenomenon of blaming pregnant women for their addiction).

44. This perspective may also animate the use of punitive measures against women who use drugs during pregnancy. See Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1440-41 (1991).

45. This phenomenon is part of a larger problem in the medical community. Women's needs generally

Women addicts, especially pregnant women, face particularly harsh social stigma.<sup>46</sup> They are more likely to have low self-esteem<sup>47</sup> and to suffer abuse. In one study, seventy percent of drug-addicted pregnant women said they had been the victims of physical abuse as adults.<sup>48</sup> Treatment regimens must be altered to address the particular needs of female clients, especially pregnant women.

"Therapy for women should . . . be provided in a style that is acceptable to and accessible by them, taking into account 'women's roles, socialization, and relative status within the larger culture.'"<sup>49</sup> Traditional treatment models, which are confrontational and punitive, are less likely to meet women's needs.<sup>50</sup> "Confrontational models reinforce low self-esteem," inhibiting a client's ability to overcome her addiction and take on economic and social responsibilities.<sup>51</sup> Mothers and pregnant women in treatment do not benefit from traditional approaches because these methods "are oriented toward helping clients develop a sense of self independent of those around them."<sup>52</sup> Treatment programs must help pregnant women address personal issues relating to childbirth, such as "parenting, bonding, neonatal withdrawal [and] guilt."<sup>53</sup> Programs that include the needs of the family unit will be more likely to meet these women's needs.<sup>54</sup> Without transformations in the drug

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have been overlooked in the field of medical research. Most research has been conducted on male subjects, thus creating a scarcity of treatments and medical instruments designed for women. See Tamar Lewin, *Doctors Consider a Specialty Focusing on Women's Health*, N.Y. TIMES, Nov. 7, 1992, at 1. In some cases, the actual definitions of illness have been based only upon men's symptoms. For example, until 1992 "the Centers for Disease Control and Prevention based the definition of AIDS entirely on men, ignoring the symptoms and diseases that typically appear in HIV-positive women. As a result, women with AIDS could not get the public assistance available to male patients." *Id.* at 10; see also Federal Old-Age, Survivor's, and Disability Insurance, 58 Fed. Reg. 36,008 (1993) (to be codified at 20 C.F.R. § 404, subpt. P, App. 1) (revised regulations regarding disability benefits for HIV-related impairments). For a discussion of gender issues in medical research, see generally Sue V. Rosser, *Re-visioning Clinical Research: Gender and the Ethics of Experimental Design*, in FEMINIST PERSPECTIVES IN MEDICAL ETHICS 127-36 (Helen B. Holmes & Laura M. Purdy eds., 1992) (examining the problems of "androcentric" medical research and identifying some benefits of eliminating such bias).

46. See Jessup, *supra* note 30, at 553.

47. See Peter Applebome, *U.S. Prisons Challenged By Women Behind Bars*, N.Y. TIMES, Nov. 30, 1992, at A10.

48. Carol Tracy et al., *Women, Babies & Drugs: Family Centered Treatment Options* 9 (1990) (unpublished manuscript, on file with the *Yale Journal of Law and Feminism*) (citing D.O. Regan et al., *Infants of Drug Addicts: At Risk for Child Abuse, Neglect and Placement In Foster Care*, 9 NEUROTOXICOLOGY & TERATOLOGY 315, 315-319 (1987)). Seventy percent of addicted pregnant women were beaten as adults. Of these, 86% were beaten by husbands or partners. *Id.*; see also Edwin Chamberlain, *Differences Abound in Male, Female Users*, U.S. JOURNAL, June 1988, at 7 (discussing differences between male and female addicts in their physical abuse histories).

49. Jessup, *supra* note 30, at 553 (quoting B.G. Reed, *Developing Women-Sensitive Drug Dependence Treatment Services: Why So Difficult?*, 19 J. PSYCHOACTIVE DRUGS 151, 151-64 (1987)).

50. Tracy & Williams, *supra* note 40, at 550.

51. *Id.* In cases where women will complete treatment and face family responsibilities, an emphasis in treatment on developing independence will not prepare them for this reality. On a broader level, some feminist theorists have argued that women generally are more connected to others, while men are more focused on individuality. For an elaborate discussion of this "connection thesis," see generally Robin West, *Jurisprudence and Gender*, 55 U. CHI. L. REV. 1 (1988).

52. Tracy & Williams, *supra* note 40, at 550.

53. Polsky, *supra* note 23.

54. Tracy & Williams, *supra* note 40, at 550.



treatment delivery system related to women's socialization and family responsibilities, women will not have "meaningful"<sup>55</sup> access to drug rehabilitation.<sup>56</sup>

## 2. *The Need for Comprehensive Treatment Services*

Drug abuse generally is part of a larger social context.<sup>57</sup> Treatment programs, in addition to targeting women's specific needs in overcoming addiction, should provide comprehensive medical care and social services to address other problems of drug-addicted pregnant women. Provision of these services improves the treatment outcomes of the women, and, in the case of pregnant women, of their newborns.<sup>58</sup>

Child care is one of the most important services that treatment programs can provide to postpartum women and other mothers. Most mothers will not remain in drug treatment unless there are on-site provisions for their children.<sup>59</sup> Women who attend residential treatment programs that accommodate their children are generally less depressed than women who must place their children with relatives or in foster care.<sup>60</sup> Yet, most programs currently do not accommodate children. In California, only sixteen of the sixty-seven publicly funded drug treatment programs that treat women also provide child care.<sup>61</sup> In New York City, only two of the eighty-seven programs accommodate children.<sup>62</sup> The number of family-centered programs must be expanded.

Treatment services for pregnant women should also include: obstetric and pediatric care,<sup>63</sup> childbirth preparation classes,<sup>64</sup> AIDS prevention counseling and treatment,<sup>65</sup> and "job and educational training," including "ongoing involvement after delivery, with an emphasis on child development and

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55. The Court in *Lau v. Nichols* stated that Chinese American students who did not speak English and had been offered an education without English language classes were "effectively foreclosed from any meaningful education." *Lau v. Nichols*, 414 U.S. 563, 566 (1974). Analogously, in the provision of drug treatment services, perhaps it could be argued that treatment in a "language" that one does not understand—i.e., male-centered approaches to recovery—constitutes sex discrimination. Whether the present Court would accept such an argument is questionable.

56. Where women in treatment will be sharing family responsibilities with a partner, a comprehensive service delivery system also should assist the partners in becoming involved in these issues.

57. Harrison, *supra* note 19, at 263.

58. See Chavkin, *supra* note 22, at 485; Jessup, *supra* note 30, at 553; Loretta P. Finnegan et al., *Scientific Foundation of Clinical Practice: Opiate Use in Pregnant Women*, 6 BULL. N.Y. ACAD. MED. 223, 238 (1991).

59. See TREATING DRUG PROBLEMS, *supra* note 6, at 234.

60. See Tracy & Williams, *supra* note 40, at 551-52.

61. See Tracy et al., *supra* note 48, at 6.

62. See *id.* See also Polsky, *supra* note 23 (discussing a Bronx program where after childbirth women must find outside care for their children or place them in foster care to stay in treatment).

63. Jessup, *supra* note 30, at 553.

64. *Id.*

65. See Finnegan et al., *supra* note 58, at 228.

parenting skills.”<sup>66</sup> Providing comprehensive services at one location is important because “[o]therwise, many addicts who have a hard time getting their lives together must travel around to get the care they need. Frequently something falls by the wayside.”<sup>67</sup>

The neglect of women’s needs in treatment sets the backdrop for the exclusion of pregnant women from these programs. Male-oriented programs marginalize women’s needs and banish the plight of pregnant drug-addicted women to the bottom of society’s priorities. Focusing attention on the needs of women addicts<sup>68</sup> will give all women better chances for recovery and will transform treatment for pregnant women into a fundamental aim rather than a peripheral concern.

### *C. When Pregnant Women are Turned Away from Treatment: The Effects of Substance Abuse Upon Pregnant Women and Their Fetuses*

Although pregnant women may face many challenges after entering drug treatment, the primary problem of those seeking help remains exclusion from treatment programs. A major consequence of denying pregnant women treatment is that their continued drug use adversely affects their health and the well-being of their fetuses.<sup>69</sup> Further, the exclusion of pregnant women from

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66. Chavkin, *supra* note 22, at 485. One example of a program that provides these services is the Family Center at Thomas Jefferson Hospital in Philadelphia. See Finnegan et al., *supra* note 58, at 228. Some states, such as New York, are beginning to provide integrated drug treatment and social services. See Polsky, *supra* note 23. The National Commission to Prevent Infant Mortality has also issued a report recommending that local government agencies provide a “one-stop shopping” system for all pregnant women, to centralize services for Medicaid, AFDC, immunizations, and prenatal care. *Death by Red Tape*, N.Y. TIMES, May 19, 1991, § 4, at 16.

67. Polsky, *supra* note 23.

68. In addition to the services discussed above, initial outreach also presents an opportunity for focusing on women’s perspectives. Consideration of women’s varying psychological, physical, and social-service needs may lead to more effective outreach to female drug users.

69. For a detailed analysis of the effects of drug use on pregnant women and their fetuses, see generally *Part III: Substance Abuse During Pregnancy*, in DRUGS AND PREGNANCY 341, 367-423 (Larry C. Gilstrap III and Bertis B. Little eds., 1992) (discussing effects of alcohol, amphetamines, marijuana, cocaine, hallucinogens, opiates, inhalants and other substances). Although many studies seem to show the harmful effects of drug use upon the fetus, it is still unclear whether improved pregnancy outcomes of addicted women who enter treatment primarily stem from a decrease in drug use or an increase in prenatal care. See Harrison, *supra* note 19, at 263. Solving this dilemma is made especially difficult because research showing that drug use has little effect on the fetus tends to be published far less than research demonstrating a positive correlation. For example, a recent report indicated that studies finding a connection between cocaine use and poor pregnancy outcome had a much greater chance of being accepted for presentation at a national conference than those finding no connection, even where the latter were better designed. See Gideon Koren et al., *Bias Against the Null Hypothesis: The Reproductive Hazards of Cocaine*, LANCET, Dec. 16, 1989, at 1440; see also Katha Pollitt, *Fetal Rights: A New Assault on Feminism*, NATION, Mar. 26, 1990, at 409, 414. The news media also tend to give prominence to studies finding strong connections between women’s drug use and pregnancy outcome, whereas those finding no connection, or those documenting the effects of a father’s drug use, receive little or no coverage. See *id.* at 414. “Published literature therefore does not represent a cross-section of knowledge, but rather only that type of data acceptable within the community of editors of medical journals.” Harrison, *supra* note 19, at 263. Despite this ambiguity, drug treatment is still urgently needed to address the addiction of the women themselves. Because drug use is generally positively correlated with lack of prenatal care, see *id.*, increased availability of treatment will positively affect birth outcomes.

drug treatment creates great social costs because the children of women who use drugs during pregnancy often experience educational and social problems.<sup>70</sup>

Pregnant women who use drugs during pregnancy often are susceptible to increased medical problems. Pregnant drug-addicted women are at a higher risk for sexually transmitted diseases, including HIV, gonorrhea, syphilis, and herpes.<sup>71</sup> They are also more likely to suffer from "poor nutrition, disruption of the menstrual cycle, hepatitis, adult-onset diabetes and hypertension."<sup>72</sup>

The pregnant woman's drug use may also harm the fetus. The fetus is most likely to develop congenital defects from drug exposure during the first trimester, particularly during the first fifty-eight days after conception.<sup>73</sup> At that time, many women do not yet know they are pregnant. Drug use during the second two trimesters also brings a risk of harming the fetus.<sup>74</sup> For example, the effects of daily marijuana use on the fetus during pregnancy include premature birth, higher chance of birth defects, and low birth weight.<sup>75</sup> The incidence of early labor and stillbirth also increases with the amount of marijuana use, and heavy intake may affect central nervous system development in the fetus.<sup>76</sup>

Cocaine use brings greater risks than marijuana to the health of the fetus, including low birth weight,<sup>77</sup> stillbirth,<sup>78</sup> spontaneous abortion,<sup>79</sup> preterm labor,<sup>80</sup> and impairment of neurological development.<sup>81</sup> Prolonged use of heroin by pregnant women produces adverse effects on fetal growth, behavior, perception, "learning processes," language, and organizational abilities in preschool age children.<sup>82</sup>

Greater access to treatment through enforcement of ADAMHA's nondiscrimination provision could prevent many of these harms. By entering

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70. See HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, NO. HRD-90-138, DRUG EXPOSED INFANTS: A GENERATION AT RISK 6 (1990).

71. See Finnegan et al., *supra* note 58, at 229; see also Bertis B. Little et al., *Introduction to Substance Abuse During Pregnancy*, in DRUGS AND PREGNANCY, *supra* note 69, at 341, 344 (noting that pregnant substance abusers are at increased risk for sexually-transmitted diseases, poor nutrition, and bacterial endocarditis); TREATING DRUG PROBLEMS, *supra* note 6, at 85 (noting that pregnant drug-addicted women are at a greater risk for infection with HIV, malnutrition, and trauma).

72. Tracy et al., *supra* note 48, at 9. Drug-addicted women who frequently use needles often "have abscesses, ulcers, thrombophlebitis, bacterial endocarditis, . . . and urinary tract infection." Finnegan et al., *supra* note 58, at 229.

73. See Little et al., *supra* note 71, at 341.

74. See *id.*

75. See DRUG SAFETY IN PREGNANCY 68-69 (Peter I. Folb & M.N. Graham Dukes eds., 1990).

76. *Id.*

77. *Id.* at 69. Nationwide, African-American infants are twice as likely as white babies to die before age one, usually due to low birth weight. See *Death by Red Tape*, *supra* note 66.

78. See DRUG SAFETY IN PREGNANCY, *supra* note 75, at 69.

79. Judith A. Ney et al., *The Prevalence of Substance Abuse in Patients with Suspected Preterm Labor*, 162 AM. J. OBSTET. & GYNECOL. 1562, 1565 (1990).

80. Luke B. Sloan et al., *Substance Abuse During Pregnancy in a Rural Population*, 79 OBSTET. & GYNECOL. 245, 246 (1992).

81. *Id.*

82. DRUG SAFETY IN PREGNANCY, *supra* note 75, at 69.

treatment, pregnant drug-addicted women would improve their own health as well as that of their fetuses. They would also receive prenatal care, thus ensuring better pregnancy outcomes. Further, these improved pregnancy outcomes would save public monies. Children of drug-addicted women who receive treatment during pregnancy would be less likely to suffer from educational and social difficulties.

## II. DANGERS OF CURRENT APPROACHES

Although state and local governments have responded to the crisis of drug abuse among pregnant women by making some effort to meet the need and demand for treatment,<sup>83</sup> many have also instituted punitive and coercive measures.<sup>84</sup> The primary punitive and coercive means for addressing the problem of drug abuse among pregnant women include prosecuting the women directly, utilizing preventive detention, and removing custody of their newborns and other children.<sup>85</sup>

Punitive and coercive responses to drug abuse among pregnant women warrant particular concern because they disproportionately affect poor women and women of color.<sup>86</sup> For example, a recent study in Florida showed that while percentages of drug use did not differ greatly between women attending public clinics and those at private offices, or between white women and African American women, health care providers were much more likely to report poor women and African American women to state health authorities.<sup>87</sup> In fact, providers were almost ten times more likely to report African American women than white women.<sup>88</sup>

Most notably, prosecutions brought against pregnant, drug-addicted women target poor women of color. In one ACLU study, over half of the defendants

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83. See, e.g., Rob Karwath, *Helping Babies of Abusers to Be Born Drug-Free*, CHI. TRIB., Nov. 25, 1990, at C1 (discussing two new programs in Chicago).

84. Coercive state-sponsored measures have also been used against women to prevent pregnancy. Women who face charges of child abuse have been forced to undergo Norplant birth control insertions to prevent them from having more children. See generally Elyse Rosenblum, *The Irony of Norplant*, 1 TEX. J. WOMEN & L. 275 (1992).

85. See generally Kary Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278 (1990).

86. For a more in depth discussion of the racial implications of punishing pregnant women for drug use, see generally Roberts, *supra* note 44. Court-ordered caesareans also have a disparate impact on women of color. A study profiling women subject to involuntary caesareans ("court-ordered obstetrical interventions") showed that "81% of the women were Black, Hispanic, or Asian, 44% were unmarried, and 24% did not speak English as their primary language." Harrison, *supra* note 19, at 265 (citation omitted).

87. Ira J. Chasnoff et al., *The Prevalence of Illicit-Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 NEW ENG. J. MED. 1202, 1204 (1990).

88. *Id.* While it could be argued that this disparity can be traced to the fact that Black women more often used cocaine while white women more often used marijuana, *id.*, the choice to punish certain forms of substance abuse over others is an initial decision that deserves to be questioned. For example, alcohol abuse, while legal, can cause great damage to a fetus.

surveyed were African American.<sup>89</sup> Recent national publicity about prosecutions in South Carolina revealed that over forty pregnant women in that state—almost all African American—had been tested for drug use without their consent and then arrested.<sup>90</sup>

These punitive responses to drug abuse by poor women of color raise significant issues. This disparate treatment on the basis of race implicates the constitutional guarantee of equal protection and the protections of other civil rights laws.<sup>91</sup> From a policy perspective, rather than targeting poor women and women of color, governments should seek less coercive solutions, such as facilitating access to treatment rather than punishing pregnant drug-addicted women in an adversarial legal system.<sup>92</sup> Expanded treatment options, such as those now available under ADAMHA, present a better alternative: they can help pregnant women overcome addiction while preserving their liberty and keeping their families together.<sup>93</sup>

#### A. Prosecution

Jennifer Johnson was the first woman in the United States to be convicted for drug use during pregnancy.<sup>94</sup> Johnson, an African American woman, was convicted of delivering cocaine to a minor—through the umbilical cord<sup>95</sup>—and sentenced to 14 years probation.<sup>96</sup> Significantly, prior to her arrest, Johnson

89. See Roberts, *supra* note 44, at 1421 n.6.

90. Philip J. Hilts, *Hospital is Object of Rights Inquiry*, N.Y. TIMES, Feb. 6, 1994, at 29. These revelations came to light amidst allegations that these women also were the unknowing subjects of human experimentation. Hilts, *supra* note 36, at A12.

91. See Golden, *supra* note 5, at 1834-35; Philip J. Hilts, *supra* note 90, at 29.

92. See Dawn Johnsen, *Shared Interests: Promoting Healthy Births Without Sacrificing Women's Liberty*, 43 HASTINGS L.J. 569, 573-79 (1992) (contrasting coercive government measures with "facilitative" methods).

93. The issue becomes more difficult with regard to those who have not sought treatment and who would not be receptive to outreach efforts. While expanding treatment availability itself will not help these women or their babies, punitive measures are still problematic.

First, they particularly affect poor women and women of color. See *supra* notes 85-92 and accompanying text. Additionally, society chooses to punish pregnant drug-addicted women because it blames them for their addiction. One commentator observed:

As with crime, as with poverty, a complicated, multifaceted problem is construed as a matter of freely chosen individual behavior. We have crime because we have lots of bad people, poverty because we have lots of lazy people . . . or lots of pathological people . . . and tiny, sickly, impaired babies because we have lots of women who just don't give a damn.

Pollitt, *supra* note 69, at 411. Some point to the media as an important contributor to this phenomenon of blaming women. See SUSAN FALUDI, *BACKLASH: THE UNDECLARED WAR AGAINST AMERICAN WOMEN* 427 (1991). Rather than blame the victims, society should seek to address these problems as part of their larger socio-economic context. For a more detailed analysis of alternatives to punishment, see Stephen R. Kandall & Wendy Chavkin, *Illicit Drugs in America: History, Impact on Women and Infants, and Treatment Strategies for Women*, 43 HASTINGS L.J. 615, 638-43 (1992) (criticizing punitive approaches and advocating alternative measures, including increasing treatment availability, drug legalization, and expanding the involvement of child protection authorities).

94. Tamar Lewin, *Court in Florida Upholds Conviction For Drug Delivery by Umbilical Cord*, N.Y. TIMES, Apr. 20, 1991, at 6.

95. See *Johnson v. State*, 578 So. 2d 419, 419 (Fla. Dist. Ct. App. 1991) (affirming trial court's convictions).

96. Lewin, *supra* note 94.

had unsuccessfully attempted to seek treatment.<sup>97</sup> Although Johnson's conviction was overturned by the Florida Supreme Court,<sup>98</sup> at least 200 women nationwide have faced criminal charges for using alcohol or drugs during pregnancy.<sup>99</sup> Efforts to bring such prosecutions continue.<sup>100</sup>

Prosecutions have found many supporters and opponents. Some law-enforcement officials view prosecutions of pregnant drug-addicted women as a means of encouraging women to seek treatment.<sup>101</sup> In Greenville, South Carolina, for example, the city solicitor claimed that since the city started prosecuting pregnant women under child neglect laws, the number of arrests had decreased because hospitals were identifying fewer cocaine babies. The solicitor said there was no evidence that women were avoiding prenatal care or hospital deliveries to avoid arrest.<sup>102</sup>

This claim, however, should be challenged. Prosecuting pregnant women does cause them to avoid seeking drug treatment and prenatal care because many pregnant drug-addicted women opt to stay out of the public eye rather than seek medical care and face possible criminal charges.<sup>103</sup> This, in turn, leads to an increase in babies born without medical attention.<sup>104</sup> Therefore, prosecutions may harm rather than improve the health of pregnant women and their fetuses.<sup>105</sup>

97. Lewin, *supra* note 18.

98. *Johnson v. State*, 602 So. 2d 1288, 1291 (Fla. 1992). The court noted that no other jurisdiction has upheld a conviction of a mother for delivery of a controlled substance to an infant through either the umbilical cord or an *in utero* transmission . . . . The Court declines the State's invitation to walk down a path that the law, public policy, reason and common sense forbid it to tread.

*Id.* at 1297. After the *Johnson* decision, the South Carolina Court of Appeals followed suit in the case of *Rosena Tolliver*, stating that the South Carolina legislature had not intended the state's drug laws to be used against pregnant women. See Alison B. Marshall, 1992 *Legislative Review*, PERINATAL ADDICTION RESEARCH AND EDUCATION UPDATE, Oct. 1992, at 1, 3. Criminal prosecutions for delivery of drugs to a minor also have failed in North Carolina and Massachusetts, see Lewin, *supra* note 94, and in Michigan, Ohio, New York, and Kentucky, see Marshall, *supra*, at 3.

99. See Krauss, *supra* note 20, at S-10. Seventy-five percent of these prosecutions have been against women of color. See *id.* at n.9. For example, Melanie Green, a 24-year-old woman in Illinois, was the first woman in the nation to face charges of manslaughter for the death of a child allegedly caused by her drug use during pregnancy. The charges were later dropped when the grand jury refused to indict her. See Walter B. Connolly and Alison B. Marshall, *Drug Addiction, Pregnancy and Childbirth: Legal Issues for the Medical and Social Services Communities*, in CENTER ON CHILDREN AND THE LAW, AMERICAN BAR ASSOCIATION, DRUG EXPOSED INFANTS AND THEIR FAMILIES: COORDINATING RESPONSES OF THE LEGAL, MEDICAL AND CHILD PROTECTION SYSTEM 31 (1990). Other theories of prosecution have included "charges of child endangerment, supplying drugs to children and assault with a deadly weapon." Hager, *supra* note 28.

100. See, e.g., Hager, *supra* note 28.

101. See Lewin, *supra* note 18.

102. *Id.*

103. See Board of Trustees, American Medical Association, *Legal Interventions During Pregnancy: Court Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2667 (1990); Lewin, *supra* note 94.

104. Susan LaCroix, *Birth of a Bad Idea: Jailing Mothers for Drug Abuse*, NATION, May 1, 1989, at 586.

105. In addition, health care providers, see Harrison, *supra* note 19, at 265, and groups opposing legalized abortion, see Krauss, *supra* note 20, at S-10, fear that criminal charges will force women into having abortions.

Nevertheless, there is significant public support for punishing pregnant women whose actions may harm their newborns. Nearly half of those surveyed in a recent poll said that a pregnant woman who smokes cigarettes, drinks alcohol, or rejects her doctor's recommendation to have a caesarean section should be held legally responsible for any damage to the fetus.<sup>106</sup> But when considering measures that restrict liberty, particularly that of individuals who do not have a strong voice in the political process, courts should be wary of majoritarian consensus.<sup>107</sup> The majority may not be sensitive to the race and class implications of prosecuting pregnant women. Such measures may also lead to significant line-drawing problems. For example, some advocates have wondered if women could be prosecuted for poor eating or exercise habits,<sup>108</sup> driving, skiing,<sup>109</sup> or not following a doctor's orders<sup>110</sup> during pregnancy. In fact, one case was brought against a woman for not following her doctor's advice, although the charges were eventually dismissed.<sup>111</sup>

In addition to being prosecuted for becoming pregnant while addicted, pregnant drug-addicted women often are "preventively detained" by judges who mete out jail sentences for minor crimes that would ordinarily result in probation or a fine . . . .<sup>112</sup> For example, in *United States v. Vaughn*,<sup>113</sup> Brenda Vaughn pled guilty to second degree theft, a charge that usually brings a sentence of probation.<sup>114</sup> The judge, however, had ordered a drug test in conjunction with the sentencing proceeding, and when Vaughn tested positive for cocaine, he explicitly stated that he was sending her to prison long enough to prevent her from using drugs again during her pregnancy.<sup>115</sup> Although sentencing always includes a broad range of considerations about the defendant, preventive detention involves incarcerating women simply to prevent drug use during pregnancy (not the crime for which they have been convicted) rather than utilizing drug use as one factor to inform the sentencing process.

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106. See LaCroix, *supra* note 104, at 586.

107. See *United States v. Carolene Prods. Co.*, 304 U.S. 144, 152 n.4 (1938).

108. See Dawn Johnsen, *From Driving to Drugs: Governmental Regulation of Pregnant Women's Lives After Webster*, 138 U. PA. L. REV. 179, 192 (1989) (noting that if state law defined legal personhood from the moment of conception, women could be prosecuted for failing to eat well).

109. See Dean S. Miller, *Idaho Governor Hit for Plan to Jail Pregnant Drug Users*, CHRISTIAN SCI. MONITOR, Jan. 24, 1991, at 8.

110. See Hager, *supra* note 28.

111. See LaCroix, *supra* note 104, at 585. Pamela Stewart was arrested for not following her doctor's advice, which included recommendations to rest, refrain from intercourse, refrain from using illegal drugs, and seek medical treatment if she experienced complications with the pregnancy. *Id.*

Stewart's husband, who had heard the doctor's advice, ignored it all and beat his wife into the bargain. Everything she did, he did—they had sex together, smoked pot together, delayed getting to the hospital together—but he was not charged with a crime, not even with wife-beating, although no one can say that his assaults were not a contributing cause of the infant's injury and death.

Pollitt, *supra* note 69, at 416.

112. Pollitt, *supra* note 69, at 409.

113. No. F-2172-88B (D.C. Super. Ct. Aug. 23, 1988), *reprinted in* 117 DAILY WASH. L. REP. 441 (1989).

114. *Id.*

115. *Id.*

Preventive detention, then, serves as a covert means of punishing pregnant women.

While preventive detention has not attracted the same attention as prosecution, it raises similar concerns. In both scenarios, women face the possibility of restricted liberty, a disproportionate (and unjust) result for those who would have entered treatment had it been available. Direct prosecutions deter women from seeking the medical care they need. Those women who remain hidden and thus do not face the threat of losing their liberty instead endanger their health and the well-being of their fetuses. This result runs counter to the goal of promoting healthy pregnancies. Expanding drug treatment options for pregnant women under ADAMHA offers a less coercive and healthier alternative for those who will seek drug treatment.

### B. Child Protection

Many states have addressed the problem of drug abuse among pregnant women by denying them custody of their newborn infants. For example, soon after Shawn S., one of the plaintiffs in *Elaine W. v. Joint Diseases North General Hospital*, discovered she was pregnant, she called or visited at least five drug treatment programs, seeking to cure her crack addiction. Each program refused to admit her. Without treatment, Shawn was unable to stop using crack. During delivery, worried that her crack use might jeopardize the health of her newborn, she informed hospital personnel about her addiction. When her daughter Thelma was born, the hospital gave her a drug test. Because of Thelma's positive toxicology, the hospital refused to release Thelma to her mother.<sup>116</sup> If Shawn S. could have found drug treatment during her pregnancy, she probably would not have lost custody of her daughter. While dependency proceedings may be required in extreme circumstances,<sup>117</sup> increasing the availability of treatment would reduce the need for this practice.<sup>118</sup>

The prospect of a less restrictive alternative is especially important because denying custody to postpartum drug-addicted women presents a number of problems. In some cases children are removed from their mothers based on one drug test, even where subsequent tests have not shown any drug use and where there have been no other indications of a drug problem.<sup>119</sup> Further,

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116. Plaintiffs' Complaint, *supra* note 26, at 11-12.

117. Even those who oppose a blanket practice of denying custody acknowledge the importance of social service involvement in some cases. See Barbara Whitaker, *Protecting Baby from Mom*, NEWSDAY, Nov. 6, 1989, at 8.

118. Many on both sides of the debate about the use of dependency proceedings against drug-addicted women agree that treatment is the best solution. LaCroix, *supra* note 104, at 586-88.

119. See, e.g., Moss, *supra* note 85, at 289-90; Whitaker, *supra* note 117, at 8. New York City's official policy requires investigations prior to removals of whether mothers are seeking treatment and have a support network. One family law attorney, however, characterized the city's practice as "grab now, ask questions later." *Id.* (quoting Florence Roberts, director of the family law unit of South Brooklyn Legal Services).



an increasing number of jurisdictions, while not instituting neglect or dependency proceedings, temporarily remove children after birth until an assessment of parental fitness can be performed. These temporary measures are undertaken without any prior individualized analysis of the child's family situation.<sup>120</sup>

More importantly, removing a newborn at birth threatens to damage permanently the parent-child relationship. "[T]he separation of mother and child could destroy what psychologists and social workers agree is a critical bonding period, causing emotional and psychological damage to the infant and feelings of overwhelming guilt and depression in the mother."<sup>121</sup> If treatment were more widely available, a greater number of families could remain together.<sup>122</sup> The denial of custody also burdens the social welfare system. In a study of ten hospitals nationwide, approximately 1200 of the 4000 drug-exposed infants born were placed in foster care, at an annual cost of \$7.2 million.<sup>123</sup> Social welfare mechanisms could function more efficiently and consume fewer tax dollars if the problem of drug-exposed infants was addressed prior to their birth.

### III. A CONGRESSIONAL RESPONSE: ENFORCING ADAMHA'S NONDISCRIMINATION PROVISION

In an effort to expand treatment availability for pregnant women, Congress passed ADAMHA's revised nondiscrimination provision, which prohibits discrimination on the basis of pregnancy in federally funded drug treatment programs.<sup>124</sup> The enforcement of this new provision will allow more women to gain entrance to treatment, thus reducing the use of punitive measures. The provision's explicit enforcement mechanisms, however, are circumscribed. The statute provides that where there has been a finding of noncompliance, notice requesting compliance must be provided to the state.<sup>125</sup> If compliance is not secured "within a reasonable period of time, not to exceed 60 days," a number of routes may be pursued.<sup>126</sup> The matter may be referred to the Attorney General, who in turn may institute a federal civil action "for such relief as may be appropriate, including injunctive relief."<sup>127</sup> Additionally, because

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120. Bonnie I. Robin-Vergeer, Note, *The Problem of the Drug-Exposed Newborn: A Return to Principled Intervention*, 42 STAN. L. REV. 745, 752 n.25 (1990).

121. LaCroix, *supra* note 104, at 586.

122. Even child protection authorities acknowledge the importance of keeping families together where such an option is possible. For example, authorities in New York City have expanded efforts to "'case manage' drug using women during pregnancy, thus hoping to reduce family disruption." Kandall & Chavkin, *supra* note 93, at 633 (quoting Joseph B. Treaster, *Plan Lets Addicted Mothers Take Their Newborns Home*, N.Y. TIMES, Sept. 19, 1991, at A1).

123. HUMAN RESOURCES DIVISION, *supra* note 70, at 7.

124. 42 U.S.C.A. § 300x-57 (West Supp. 1993).

125. *Id.* § 300x-57(b).

126. *Id.*

127. *Id.*

ADAMHA recipients are subject to four other civil rights statutes, remedies under these statutes may be available where noncompliance is found. Finally, the Attorney General may take "other actions as may be authorized by law."<sup>128</sup> Thus, enforcement of ADAMHA's nondiscrimination provision is overtly limited to action by the Attorney General; private causes of action are not expressly granted.

Remedial schemes, however, are not always restricted by a literal reading of the statute. Private rights of action may be implied even when they are not expressly provided for in the statute. Therefore, in examining the ability of the nondiscrimination provision to help pregnant women seek treatment, it must be determined whether women can bring suit under the statute to enforce their rights or whether they must rely on government enforcement mechanisms. A related issue is whether pregnant women can enforce their rights by bringing a civil rights action under 42 U.S.C. § 1983.<sup>129</sup> A § 1983 suit offers the possibility of securing attorney's fees for the plaintiffs,<sup>130</sup> thus enabling actions to go forward that otherwise may not have been brought. Additionally, potential defendants and available remedies must be identified. This Section will explore these issues, examining the choices that plaintiffs may face in the process of enforcing their rights and recommending particular legal avenues for maximizing the effect of ADAMHA's nondiscrimination provision.

#### *A. Is There a Private Right of Action Under the Statute?*

The nondiscrimination provision of the ADAMHA Reorganization Act does not explicitly provide for private enforcement. Thus, individuals seeking to bring an action under the statute must show that a court should imply such a remedy. In *Cort v. Ash*,<sup>131</sup> the Supreme Court first set out the test for determining whether a private cause of action should be implied under a federal statute. The *Cort* analysis asked four questions:

First . . . does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such

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128. *Id.*

129. Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983 (1988). The question of whether there is an implied right of action turns on the definition of "and laws."

130. *Id.* § 1988.

131. 422 U.S. 66 (1975).

a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?<sup>132</sup>

Soon after establishing this test, however, the Court began to prioritize some elements over others, ultimately focusing on the question of congressional intent. In *Touche Ross and Company v. Redington*,<sup>133</sup> the Court considered whether customers of securities brokerage firms could bring a private action against accountants who allegedly made improper audits of an insolvent firm under § 17(a) of the Securities Exchange Act of 1934. In declining to apply all four *Cort* factors, Justice Rehnquist explained that the criteria were not meant to be granted equal weight. Rather, “[t]he central inquiry remains whether Congress intended to create, either expressly or by implication, a private cause of action.”<sup>134</sup> Applying the first three *Cort* factors, Justice Rehnquist found that the statutory language did not grant a private action, that the intent of the statute was only to regulate businesses (not to create private rights), that the legislative history was silent on the question of private remedies, and that statutory provisions surrounding the one in question, by contrast, did explicitly allow for private actions.<sup>135</sup> Accordingly, Rehnquist held that no private cause of action should be granted.

Two years later, in *Northwest Airlines v. Transport Workers Union of America*,<sup>136</sup> the Court underlined its focus on congressional intent by noting that the inquiry must end where neither of the first two *Cort* factors are satisfied.<sup>137</sup> In *Northwest*, the petitioner had previously been held liable for sex discrimination under both the Equal Pay Act and Title VII and was seeking contribution from union signatories to the labor agreement. In denying a private right to contribution, the Court found that neither the language nor structure of the statutes, nor their legislative histories, supported the notion that Congress intended to provide such a remedy.<sup>138</sup> The congressional intent analysis was dispositive.

Justice Marshall reaffirmed the use of the congressional intent standard for implied causes of action in *Thompson v. Thompson*.<sup>139</sup> In denying a private remedy to a parent seeking declaratory and injunctive relief regarding conflicting state child custody orders, the Court asserted that congressional intent was the “essential predicate” for implying an action.<sup>140</sup> Specifically,

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132. *Id.* at 78 (citations omitted).

133. 442 U.S. 560 (1979).

134. *Id.* at 575.

135. *Id.* at 569-72.

136. 451 U.S. 77 (1981).

137. *Id.* at 94 n.31.

138. *Id.* at 92-95.

139. 484 U.S. 174 (1988).

140. *Id.* at 179.

in examining the Parental Kidnapping Prevention Act, the Court looked at three elements demonstrative of congressional intent: context, language, and legislative history.<sup>141</sup>

The Court's evolving interpretation of *Cort* indicates that whether private actions under the ADAMHA nondiscrimination provision will be recognized turns on an analysis of congressional intent. This analysis must focus on the first two *Cort* factors and examine the purpose, language, and structure of the statute, as well as the historical context in which the statute was passed.

The first *Cort* factor, whether the statute was meant to benefit the putative plaintiff, is satisfied where the provision in question either confers a right on private parties or prohibits particular conduct.<sup>142</sup> The nondiscrimination provision of the ADAMHA Reorganization Act easily satisfies this test. The language of the statute focuses on the rights conferred upon individuals not to be "excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded" with ADAMHA block grant monies.<sup>143</sup> In granting this right to private parties, the law clearly proscribes discrimination by treatment programs receiving ADAMHA grants.<sup>144</sup>

In discussing the second *Cort* factor, congressional intent to create or deny a private remedy, the Court has pointed out that as a practical matter "the legislative history of a statute that does not expressly create or deny a private remedy will typically be equally silent or ambiguous on the question."<sup>145</sup> Thus, "the failure of Congress expressly to consider a private remedy is not inevitably inconsistent with an intent on its part to make such a remedy available. Such an intent may appear implicitly in the language or structure of the statute, or in the circumstances of its enactment."<sup>146</sup> Therefore, these factors—statutory language, statutory structure, and historical context—should be examined in determining whether Congress intended to grant a private remedy.

The language and structure of a statute disallow a private action only where Congress has created a complex remedial scheme. The Court has held that

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141. *Id.* at 180.

142. See *Transamerica Mortgage Advisors v. Lewis*, 444 U.S. 11, 23-24 (1979); *Touche Ross & Co. v. Redington*, 442 U.S. 560, 569 (1979).

143. 42 U.S.C. § 300x-57(a) (West Supp. 1993).

144. In *California v. Sierra Club*, 451 U.S. 287 (1981), the Court explained that the first *Cort* element is not met where the plaintiffs only benefit indirectly from the statute. *Cort* requires that "Congress intended to confer federal rights upon those beneficiaries." *Id.* at 294 (citing *Cannon v. Univ. of Chicago*, 441 U.S. 677, 690-93 n.13 (1979)). In *Sierra Club*, the plaintiffs brought an action under a federal statute that prohibited the obstruction of navigable waterways. The language of the statute did not point to particular beneficiaries, but rather stated "a general proscription of certain activities." *Sierra Club, Id.* at 294. Thus, while the plaintiffs did in fact benefit from unobstructed waterways, there was no evidence that Congress had created the law for the benefit of the plaintiffs. This dilemma does not present itself under the ADAMHA provision. ADAMHA creates a direct benefit to the plaintiffs—freedom from discrimination—rather than the indirect benefit created by the *Sierra Club* statute.

145. *Thompson*, 484 U.S. at 179 (citation omitted).

146. *Lewis*, 444 U.S. at 18; see *Thompson*, 484 U.S. at 179.

such a detailed scheme indicates that Congress intended to delineate the full scope of available remedies under a statute and that the Court is therefore bound by the articulated remedies.<sup>147</sup> ADAMHA's nondiscrimination provision does not provide such a comprehensive remedial scheme. Although it generally empowers the Attorney General to enforce the statute,<sup>148</sup> it does not explicitly allow for private individuals to enforce their rights. ADAMHA's general provision stands in contrast with the detailed remedies that foreclosed private rights of action in *Northwest Airlines v. Transport Workers Union of America* and *Karahalios v. National Federation of Federal Employees*. The statute at issue in *Northwest* allowed for "private enforcement in certain carefully defined circumstances, and provide[d] for enforcement at the instance of the Federal Government in other circumstances."<sup>149</sup> Similarly, the statute at issue in *Karahalios* offered judicial access in only three circumstances.<sup>150</sup> Because ADAMHA does not include such a detailed remedial scheme, Congress apparently did not intend to provide the full scope of available remedies. Rather, Congress intended the courts to allow private actions.

The circumstances surrounding a statute's enactment provide an additional source of guidance under the second *Cort* factor. This inquiry contains two parts: an analysis of the legislative history of the statute itself and an examination of the context in which it was enacted.<sup>151</sup> As discussed above, when a statute is silent on the subject of private remedies, it is not surprising that the legislative history will be equally silent. Thus, legislative history must serve as a source of *implicit* support for a private right of action.<sup>152</sup>

While the legislative history of the ADAMHA Reorganization Act does not discuss private enforcement, it does focus on the treatment crisis among pregnant, drug-addicted women. It specifically acknowledges that blanket exclusions of pregnant women must end. For example, Senators Bob Graham

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147. See *Karahalios v. Nat'l Fed'n of Fed. Employees*, 489 U.S. 527, 533 (1989); *Northwest Airlines v. Transp. Workers Union*, 451 U.S. 77, 93-95 (1981).

148. See 42 U.S.C.A. § 300x-57 (West Supp. 1993).

149. *Northwest*, 451 U.S. at 93.

150. *Karahalios*, 489 U.S. at 532.

151. See *Thompson v. Thompson*, 484 U.S. 174, 179 (1988).

152. The majority in *Thompson* explained,

Our focus on congressional intent does not mean that we require evidence that Members of Congress, in enacting the statute, actually had in mind the creation of a private cause of action. The implied cause of action doctrine would be a virtual dead letter were it limited to correcting drafting errors when Congress simply forgot to codify its evident intention to provide a cause of action.

*Id.* In his concurrence, Justice Scalia disputed this point, stating that while congressional intent must not be explicitly declared, subjective intent is required and may be "inferred from various indicia." *Id.* at 189 (Scalia, J., concurring). Justice Scalia's disagreement indicates his more general discomfort with implying rights of action from federal statutes. Focusing on the importance of separation of powers, Justice Scalia said that he would eliminate the Court's role in implying private remedies and instead would rely on Congress. He cited three reasons for deferring to Congress: Congress' power under Article III to determine the jurisdiction of the federal courts, Congress' role in defining the reach of its own legislation, and Congress' ability to create a private right of action when it chooses to do so. *Id.* at 191-92 (citing *Cannon v. Univ. of Chicago*, 441 U.S. 677, 730 (1979) (Powell, J., dissenting)). For now, Justice Scalia's approach remains a minority view.

and Connie Mack described to the U.S. Senate the pressing need in Florida for treatment of pregnant, addicted women. Senator Graham noted that "[o]nly 1,500 of the 10,000 pregnant women in Florida in need of treatment receive services."<sup>153</sup> Senator Mack then explained, "The human element of this legislation is immeasurable. . . what I am really arguing for is access to the system for the 21-year-old crack cocaine-addicted pregnant woman who statistics say will more than likely have additional substance exposed newborns if she does not get treatment."<sup>154</sup>

Similarly, on the floor of the U.S. House of Representatives, Representative Richard Durbin declared:

Unfortunately, many of our Nation's residential treatment programs currently refuse to serve pregnant women or refuse to make provision for their children. As a result, pregnant women who desperately need treatment languish on the waiting lists for the few programs that are available. While they look for a program that has an opening and will accept them, they and their children suffer the continuing effects of their addiction.<sup>155</sup>

Clearly, the crisis of drug abuse among pregnant women informed Congress' passage of the ADAMHA Reorganization Act. While this evidence alone may not be enough to warrant a private remedy, it lends support to the congressional intent argument. As the Court has pointed out, a statute without an explicit grant of private remedies often has legislative history that is silent on the issue. Thus, a focus by individual members of Congress on the urgency of the problem and the plight of individual members of society may be the only evidence available in the legislative history.

In such circumstances, the context in which Congress has acted in passing a statute may prove especially useful in discerning congressional intent. This is particularly true where the Court, prior to the law's enactment, has found a private right of action under similar legislation.<sup>156</sup> When Congress enacted the nondiscrimination provision of the ADAMHA Reorganization Act, it did so against the background of four civil rights statutes containing almost identical language. Thus, an examination of the availability of private rights of action under Title VI of the Civil Rights Act of 1964 (Title VI),<sup>157</sup> Title

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153. 138 CONG. REC. S7651 (daily ed. July 1, 1992) (statement of Sen. Graham).

154. *Id.* (statement of Sen. Mack).

155. *Id.* at H5708 (statement of Rep. Durbin).

156. See *Thompson*, 484 U.S. at 189-90 (Scalia, J., concurring) (arguing that context should be relevant in the determination of intent only when interpreting related legislation or the same legislation prior to its reenactment); *Cannon v. University of Chicago*, 441 U.S. 677, 718 (1979) (Rehnquist, J., concurring)(noting Congress' silence at the time of enactment of similar legislation as a reliance on the Court to decide whether a private right of action should exist).

157. "No person . . . shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d (1988).

IX of the Education Amendments of 1972 (Title IX),<sup>158</sup> § 504 of the Rehabilitation Act of 1975 (§ 504),<sup>159</sup> and the Age Discrimination Act of 1975 (Age Discrimination Act)<sup>160</sup>—which proscribe various types of discrimination by recipients of federal funding—informs the analysis of private remedies for pregnancy discrimination under ADAMHA.

These four statutes are especially appropriate for analyzing the ADAMHA nondiscrimination provision for several reasons. First, they all contain language similar to that in ADAMHA and therefore seem to require similar interpretive approaches. Second, like ADAMHA, they all pertain to federally funded programs and thus operate with similar assumptions about the relationship between funding recipients and the respective funding agency. Third, ADAMHA's section on nondiscrimination includes a provision affirming the applicability of these four statutes to recipients of ADAMHA block grants,<sup>161</sup> implying similar types of obligations. Finally, the four statutes are treated together in the Civil Rights Remedies Equalization Act,<sup>162</sup> which allows damage remedies in suits against states, suggesting their comparable remedial schemes.

An examination of private rights of action under the four analogous civil rights statutes begins with the test initially set forth by the Supreme Court in a Title IX case. In *Cannon v. University of Chicago*,<sup>163</sup> a female plaintiff sued two universities for sex discrimination in their medical school admittance procedures. The Supreme Court held that a private cause of action existed under Title IX. In reaching that conclusion, the Court applied the four-part *Cort* test.<sup>164</sup> It found that the statute was enacted for the benefit of the plaintiff, as she was claiming to be a victim of the discrimination explicitly proscribed by Title IX.<sup>165</sup> The Court also found that Congress clearly intended to create a private cause of action. Justice Stevens explained that Title IX was modeled on Title VI, with the assumption that it would be interpreted similarly. Because lower federal courts had already construed Title VI to allow a private remedy at the time Title IX was passed, Congress believed Title IX would include a private action.<sup>166</sup> The Court also observed that granting a private remedy would effectuate the legislative purpose of protecting

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158. "No person . . . shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance . . . ." 20 U.S.C. § 1681(a) (1988).

159. "No otherwise qualified individual with handicaps . . . shall, solely by reason of her or his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." 29 U.S.C. § 794(a) (1988).

160. "[N]o person . . . shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 6102 (1988).

161. See 42 U.S.C.A. § 300x-57(a)(1) (West Supp. 1993).

162. See 42 U.S.C. § 2000d-7 (1988).

163. 441 U.S. 677 (1979).

164. See *Cannon*, 441 U.S. at 688.

165. See *id.* at 689-94.

166. See *id.* at 694-703.

individuals from discrimination.<sup>167</sup> Finally, the court found that allowing such a remedy would not intrude upon a traditional area of state concern, since anti-discrimination laws were well established as within the purview of the federal government.<sup>168</sup> After applying the *Cort* test, Justice Stevens stated that concerns regarding the cost and volume of private actions did not override the Court's conclusion that Title IX provides a private remedy.<sup>169</sup>

Although the Court in *Cannon* relied on the four-part *Cort* test rather than the revised test which focuses solely on congressional intent,<sup>170</sup> both Congress and the Supreme Court have since affirmed *Cannon*'s holding. Congress' first action that indicated approval of *Cannon* was the Civil Rights Remedies Equalization Act (CRREA). The 1986 amendment to the Rehabilitation Act abrogated the states' Eleventh Amendment immunity from damages under Title IX, Title VI, § 504, and the Age Discrimination Act.<sup>171</sup> By allowing private individuals to recover damages from the states, Congress impliedly approved of actions by private plaintiffs. In *Franklin v. Gwinnett County Public Schools*,<sup>172</sup> the Supreme Court underlined this interpretation of Congress' intent with regard to private remedies under Title IX. It noted that the CRREA "cannot be read except as a validation of *Cannon*'s holding."<sup>173</sup> "This is not a situation, then, where the correctness of [the] Court's statutory interpretation is supported only by congressional acquiescence. Rather, Congress here has enacted legislation strongly indicating the correctness of [the] Court's decision."<sup>174</sup> Further, a second piece of federal legislation also indicates congressional approval of *Cannon*. When Congress passed the more recent Civil Rights Restoration Act of 1987,<sup>175</sup> it did not take this opportunity to limit implied causes of action. In fact, many of the judicial decisions discussed in the legislative history of the Act were private actions.<sup>176</sup> Thus, *Cannon*'s holding that a private right of action exists under Title IX remains good law.

Relying in part on its holding in *Cannon*, the Court has also found private causes of action under Title VI and § 504. In the Court's first Title VI case,

167. *See id.* at 703-08.

168. *See id.* at 708-09.

169. *See id.* at 709-10.

170. For a discussion of the evolution of the *Cort* test, see *supra* notes 132-40 and accompanying text.

171. A State shall not be immune under the Eleventh Amendment of the Constitution of the United States from suit in Federal court for a violation of section 794 of Title 29, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975 . . . title VI of the Civil Rights Act of 1964 . . . or the provisions of any other Federal statute prohibiting discrimination by recipients of Federal financial assistance.

42 U.S.C.A. § 2000d-7(a)(1) (West Supp. 1993).

172. 112 S.Ct. 1028 (1992).

173. *Id.* at 1036; *see also id.* at 1039 (Scalia, J., concurring).

174. Brief of National Women's Law Center et al. as *Amici Curiae* in Support of Petitioner at 8, *Franklin v. Gwinnett County Pub. Schs. Dist.*, 112 S. Ct. 1028 (1992) (No. 90-918).

175. Pub. L. No. 100-259, 102 Stat. 28 (1988).

176. *See, e.g.*, S. REP. No. 64, 100th Cong., 1st Sess. 10-11, 14-16 (1987).



*Lau v. Nichols*,<sup>177</sup> the Court adjudicated a class action suit by Chinese-American students against the San Francisco school district for unequal educational opportunities. The Court decided the case without addressing the question of whether there was a private right of action, thus implying that one existed. Four years later, in *Regents of the University of California v. Bakke*,<sup>178</sup> where a white male applicant challenged the affirmative action admissions policies of a state medical school, four Justices found that there was a private cause of action,<sup>179</sup> and four more explicitly assumed that one existed.<sup>180</sup> In its most recent Title VI decision, *Guardians Association v. Civil Service Commission of New York*,<sup>181</sup> the Court relied on both *Bakke* and *Cannon* to articulate explicitly a private right of action. The *Guardians* court explained that in *Cannon*, "[a] major part of the analysis was that Title IX had been derived from Title VI, that Congress understood that private remedies were available under Title VI, and that Congress intended similar remedies to be available under Title IX."<sup>182</sup> Because the language of ADAMHA's nondiscrimination provision is modeled upon these two statutes, the same reasoning can and should be applied to private causes of action under ADAMHA.

The Court's discussions of private causes of action under § 504 have been much briefer. In the Court's first § 504 decision, *Southeastern Community College v. Davis*,<sup>183</sup> the Court arrived at the merits of the case without addressing whether there was a private cause of action.<sup>184</sup> The following year, in a suit against a railroad employer alleging discrimination on the basis of a disability, the Court, relying on its earlier Title VI analysis, held that a private cause of action existed under § 504.<sup>185</sup> Subsequently, the Court reached the merits of a class action suit in *Alexander v. Choate*,<sup>186</sup> in which Medicaid recipients challenged a state's reduction of the number of days of inpatient hospital care covered under its Medicaid program, without addressing the question of whether there was an implied right of action.

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177. 414 U.S. 563 (1974).

178. 438 U.S. 265 (1978).

179. *Id.* at 418-21 (Stevens, J., concurring in part and dissenting in part).

180. *See id.* at 283 (opinion of Powell, J.); *id.* at 328 (Brennan, J., concurring in part and dissenting in part). One Justice found no cause of action but seemed to indicate that he may have accepted a § 1983 action. *See id.* at 380-81, 387 (opinion of White, J.); *see also* *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582, 594 n.17 (1983) (opinion of White, J.) (discussing Justice White's approach in *Bakke*).

181. 463 U.S. 582 (1983).

182. *Guardians*, 463 U.S. at 594 (citing *Cannon*, 441 U.S. at 694-703); *see also id.* at 635-36 (Stevens, J., dissenting).

183. 442 U.S. 397 (1979).

184. *Id.* at 404 n.5.

185. *See* *Consol. Rail Corp. v. Darrone*, 465 U.S. 624, 626 (1984). Because the defendant abandoned its claim that there was no private right of action under § 504, the Court did not address this point explicitly. *Id.* at 630 n.7.

186. 469 U.S. 287 (1985).

Although the Supreme Court has not addressed the question of private remedies under the Age Discrimination Act, a number of federal district courts have explored the issue. One district court found no private right of action,<sup>187</sup> although it did so without any accompanying analysis.<sup>188</sup> Subsequently, however, "all courts . . . that have faced the issue have resolved it in favor of a private cause of action."<sup>189</sup> Thus, when Congress passed the recent ADAMHA Reorganization Act, private causes of action were available under the Age Discrimination Act, Title VI, § 504, and Title IX, all of which contain nondiscrimination provisions similar to that in ADAMHA. Accordingly, courts should recognize an implied private cause of action under ADAMHA.

A comparison with the four civil rights statutes also demonstrates that the ADAMHA enforcement provision vesting power in the U.S. Attorney General does not preclude a private right of action. As discussed above, ADAMHA explicitly grants power to the Attorney General to enforce its nondiscrimination provision.<sup>190</sup> Similarly, pursuant to an Executive Order,<sup>191</sup> the Attorney General has the power to coordinate the enforcement of Title VI, Title IX, and § 504 and any federal statutes that prohibit discrimination in federally assisted programs,<sup>192</sup> such as ADAMHA. Since the Attorney General's enforcement power has in no way limited the availability of private remedies under the three civil rights statutes,<sup>193</sup> the same should be true of ADAMHA. An analysis of the Age Discrimination Act offers a similar conclusion. While the Attorney General's role in enforcing the Age Discrimination Act has been established in the statute itself,<sup>194</sup> this has not been cited as any cause for hesitation in implying private rights of action.

Finally, a brief overview of the four analogous civil rights statutes indicates that ADAMHA should not require private plaintiffs to exhaust administrative remedies, such as hearings before executive-branch agencies and related appeals, before pursuing private actions.<sup>195</sup> Of the four statutes, the Supreme

187. *Mittelstaedt v. Board of Trustees of the Univ. of Ark.*, 487 F. Supp. 960, 965 (E.D. Ark. 1980).

188. *Id.*

189. *Rannels v. Hargrove*, 731 F. Supp. 1214, 1220 (E.D. Pa. 1990). *See NAACP v. Wilmington Medical Ctr., Inc.*, 491 F. Supp. 290, 293 n.12 (D. Del. 1980) (assumed without deciding that there was a private right of action under the Age Discrimination Act), *aff'd sub nom.*, 657 F.2d 1322 (3d Cir. 1981) (en banc); *Stephanidis v. Yale Univ.*, 652 F. Supp. 110, 112 n.\* (D. Conn. 1986), (questioning the holding in *Mittelstaedt*), *aff'd mem.*, 814 F.2d 654 (2d Cir. 1987).

190. *See supra* note 126 and accompanying text.

191. *See Exec. Order No. 12,250*, 3 C.F.R. 298 (1981), *reprinted in* 42 U.S.C. § 2000d-1 (1988).

192. The order allows the Attorney General to enforce

[a]ny other provision of Federal statutory law which provides, in whole or in part, that no person in the United States shall, on the ground of race, color, national origin, handicap, religion, or sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance.

*Id.* § 1-201(d).

193. *See supra* notes 165-87 and accompanying text.

194. *See* 42 U.S.C. § 6104(e)(1) (implying a role for the Attorney General by requiring that private plaintiffs provide notice to her before bringing an action).

195. This inquiry provides the only source of information on this question, because, as with the subject of private rights of action, the language and legislative history of the statute are silent on the issue of exhaustion.

Court has found that administrative exhaustion is required by the Age Discrimination Act only, where the requirement is explicitly provided for in the statute.<sup>196</sup> By contrast, the Court has entertained § 504 and Title VI cases without requiring administrative exhaustion.<sup>197</sup> Because ADAMHA, like Title VI, Title IX and § 504, does not provide explicitly for exhaustion, private plaintiffs should be able to gain direct access to federal court.

As the above discussion illustrates, courts should recognize a private remedy under ADAMHA's nondiscrimination clause. A careful analysis of the legislative history, historical context, and close relationship to other civil rights statutes reveals that ADAMHA meets the first two *Cort* factors and their focus on congressional intent. Therefore, an implied right of action exists under ADAMHA.

### B. *Is There a Private Right of Action Under § 1983?*

Rather than seeking a private remedy directly under the statute, a plaintiff might want to bring an action against the state or a state actor under 42 U.S.C. § 1983<sup>198</sup> because it allows her to recover attorney's fees.<sup>199</sup> Further, should a court find that private actions are not available under ADAMHA, § 1983 still provides a means of bringing a case in federal court because the test for determining whether there is a private cause of action under § 1983 differs from that applied directly under the statute. One disadvantage of bringing a case under § 1983 is that potential defendants must be state actors.<sup>200</sup> While a public hospital or treatment program will be subject to suit as a state actor,

196. See 42 U.S.C. § 6104(f); see also 45 C.F.R. § 90.50 (1993).

197. See, e.g., *Alexander v. Choate*, 469 U.S. 287 (1984) (discussing § 504); *Guardians Ass'n v. Civil Serv. Comm'n of New York*, 463 U.S. 582, 593-95 (1983) (discussing Title VI); *Southeastern Community College v. Davis*, 442 U.S. 397 (1979) (discussing § 504). In a dissenting opinion in a case regarding attorney's fees, Justice Brennan confirmed the implication that Title VI does not seem to require administrative exhaustion. See *North Carolina Dep't of Transp. v. Crest St. Community Council*, 479 U.S. 6, 21 (1986) (Brennan, J., dissenting) (noting that Title VI plaintiffs are "unfettered" by requirement to exhaust administrative remedies). Further, circuit courts have explicitly stated that § 504 does not require administrative exhaustion. See, e.g., *Smith v. Barton*, 914 F.2d 1330, 1338 (9th Cir. 1990) ("private plaintiffs suing under § 504 need not first exhaust administrative remedies"); *Miener v. Missouri*, 673 F.2d 969, 978 (8th Cir. 1982) ("§ 504 suits appropriately may be maintained in advance of the exhaustion of administrative remedies.").

198. For text of § 1983, see *supra* note 128.

199. The Civil Rights Attorney's Fees Awards Act of 1976 amended 42 U.S.C. § 1988 by adding the following provision:

In any action or proceeding to enforce a provision of sections 1981, 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318 [20 U.S.C. 1681 et seq.], or in any civil action or proceeding, by or on behalf of the United States of America, to enforce, or charging a violation of, a provision of . . . title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.

42 U.S.C. § 1988. Fees are available in both federal and state courts. See *Maine v. Thiboutot*, 448 U.S. 1, 8-11 (1980). Recovery of attorney's fees is crucial because it enables plaintiffs who otherwise would not be able to bring suits to enforce their rights in court.

200. For a discussion of strategies for identifying potential defendants, see *infra* notes 246-56 and accompanying text.

it is unlikely that a private institution receiving public funds would be subject to suit under § 1983.<sup>201</sup> Therefore, plaintiffs bringing actions against private treatment programs may be limited to suing directly under the ADAMHA statute. An additional limitation on plaintiffs pursuing § 1983 claims is that they may only seek injunctive relief.<sup>202</sup> Where they seek damages from a state, they will have to sue directly under ADAMHA. Nevertheless, the broader test for implied actions and the availability of attorney's fees under § 1983 make it an important instrument for plaintiffs seeking injunctive relief from state actors.

In *Maine v. Thiboutot*,<sup>203</sup> the Supreme Court held for the first time that there is a cause of action under § 1983 to enforce a violation of a federal statute by a state actor.<sup>204</sup> The Court stated that the plain language of § 1983 covers statutory as well as constitutional claims<sup>205</sup> and that the somewhat "scanty" legislative history of the statute offers no reason to override its apparent meaning.<sup>206</sup>

Following this decision, the Court established two exceptions to the general presumption in favor of § 1983 remedies for statutory violations: "where Congress has foreclosed such enforcement of the statute in the enactment itself and where the statute did not create enforceable rights, privileges, or immunities within the meaning of § 1983."<sup>207</sup> This approach differs from that in *Cort*, because the *Cort* "test reflects a concern, grounded in separation of powers, that Congress rather than the courts controls the availability of remedies for violations of statutes."<sup>208</sup> Because § 1983 expressly authorizes private rights of action, separation of powers concerns are not implicated. Thus, whereas under *Cort* a plaintiff must affirmatively demonstrate that a right of action exists, under § 1983 a right of action will be assumed unless "Congress has affirmatively withdrawn the remedy."<sup>209</sup>

Congressional intent to foreclose a § 1983 remedy—the first exception—may be indicated by a comprehensive statutory remedial scheme.<sup>210</sup> Only two Supreme Court cases have identified remedial systems sufficient to preclude a § 1983 action: *Middlesex County Sewerage Authority*

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201. See *Rendell-Baker v. Kohn*, 457 U.S. 830, 839-43 (1982) (holding that a private school that received over 90% of its financial support from public funds was not a state actor).

202. See *infra* notes 279-80 and accompanying text (noting that the Civil Rights Remedies Equalization Act only abrogates state immunity from damage actions for cases brought directly under the statute).

203. 448 U.S. 1 (1980).

204. See *id.* at 4-5.

205. See *id.* at 4. Section 1983 covers the "deprivation of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C. § 1983 (1988) (emphasis added).

206. See *Maine*, 448 U.S. at 7-8.

207. *Wright v. City of Roanoke Redevelopment and Housing Auth.*, 479 U.S. 418, 423 (1987).

208. *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 509 n.9 (1990).

209. *Id.*

210. The burden is on the defendant to show that such a scheme forecloses a § 1983 remedy. See *Wilder*, 496 U.S. at 520-21; *Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 21 n.31 (1981).

v. *National Sea Clammers Association*<sup>211</sup> and *Smith v. Robinson*.<sup>212</sup> Unlike the ADAMHA Reorganization Act, the statutes involved in these cases explicitly offered judicial remedies for private plaintiffs.<sup>213</sup> The *Sea Clammers* environmental statutes provided for a variety of enforcement provisions, including government suits for civil and criminal penalties and private actions for injunctive relief,<sup>214</sup> while the Education of the Handicapped Act<sup>215</sup> at issue in *Smith* offered comprehensive administrative and judicial remedial schemes beginning at the local level.<sup>216</sup> (The statutory remedies in *Smith* were meant to allow states to retain their traditional role in overseeing education.)<sup>217</sup> Because ADAMHA has a quite general remedial scheme and explicitly grants no private judicial or administrative remedies,<sup>218</sup> it is unlikely that *Sea Clammers* or *Smith* forecloses § 1983 remedies for violations of ADAMHA.<sup>219</sup>

ADAMHA's general remedial scheme is more analogous to that at issue in *Wilder v. Virginia Hospital Association*.<sup>220</sup> In *Wilder*, the Court found that a § 1983 remedy was not foreclosed for private actions alleging violations of the Medicaid Act, a statute with a delineated yet limited enforcement scheme. Like ADAMHA's nondiscrimination clause, the Medicaid Act does not explicitly provide private judicial or administrative remedies, but rather allows the Federal executive branch to act. Specifically, under the Medicaid Act, the Secretary can withhold funds to obtain statutory compliance.<sup>221</sup> While the ADAMHA statute offers such a remedy,<sup>222</sup> it also provides particular enforcement procedures under the nondiscrimination clause itself.<sup>223</sup> Nevertheless, ADAMHA's nondiscrimination enforcement mechanisms empowering the Attorney General stand in stark contrast to the highly detailed judicial and administrative schemes flagged by the Court in *Sea Clammers* and *Smith*.<sup>224</sup> Thus, while ADAMHA's enforcement mechanisms may be

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211. 453 U.S. 1 (1981).

212. 468 U.S. 992 (1984).

213. See *Smith*, 468 U.S. at 1009; *Sea Clammers*, 453 U.S. at 20; see also *Wilder*, 496 U.S. at 520-21 (discussing why § 1983 remedies were foreclosed in *Sea Clammers* and *Smith*).

214. *Sea Clammers*, 453 U.S. at 13-14.

215. This statute is now known as the Individuals with Disabilities Education Act. See 20 U.S.C.A. § 1400(a) (West Supp. 1994).

216. See *Smith*, 468 U.S. at 1009-13.

217. *Id.* at 1010.

218. See 42 U.S.C.A. § 300x-57 (West Supp. 1993); see also *supra* text accompanying notes 125-28 (explaining the nondiscrimination provision's enforcement mechanisms).

219. ADAMHA plaintiffs would be relying on what seems to be quite a strong presumption in favor of private § 1983 actions. For example, the Court has held that the existence of a state administrative remedy does not automatically foreclose access to a § 1983 action in federal court. See *Wright v. City of Roanoke Redevelop. & Hous. Auth.*, 479 U.S. 418, 427-28 (1987) (citing *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982)).

220. 496 U.S. 498 (1990).

221. See *id.* at 521.

222. See 42 U.S.C.A. § 300x-55(a) (West Supp. 1993).

223. See 42 U.S.C.A. § 300x-57(a), (b) (West Supp. 1993).

224. See *Wilder*, 496 U.S. at 521. The *Wilder* Court noted that in *Sea Clammers* the enforcement scheme "granted the Environmental Protection Agency considerable enforcement power through the use

somewhat more expansive than those in the Medicaid Act, they still remain in the realm of general executive branch schemes. Accordingly, Congress has not foreclosed the availability of § 1983 remedies for violations of ADAMHA.

The question remains whether ADAMHA creates enforceable rights within the meaning of § 1983. There are two situations in which a right may not be enforceable: 1) when the statute demonstrates a congressional preference rather than a mandate, and 2) when the right created is too vague to be enforced by the judiciary.<sup>225</sup> In *Pennhurst State School v. Halderman*,<sup>226</sup> the Court held that a § 1983 remedy was not available because the provision the plaintiffs sought to enforce merely indicated a congressional preference rather than a mandate for specific treatment of people with disabilities.<sup>227</sup> Compliance with this preference was not a condition of federal funding.<sup>228</sup> Therefore, the *Pennhurst* plaintiffs could not bring a § 1983 action to secure treatment in the least restrictive environment for people with developmental disabilities.

In *Wilder and Wright v. City of Roanoke Redevelopment and Housing Authority*, however, the Court found that the statutes in question indicated a congressional mandate, creating enforceable rights. In *Wright*, the Brooke Amendment to the Housing Act established rent ceilings for tenants in low-income public housing projects.<sup>229</sup> In *Wilder*, the Boren Amendment to the Medicaid Act provided specific guidelines for setting "reasonable and adequate" reimbursement rates to health care providers and conditioned federal funding on compliance with the amendment.<sup>230</sup> ADAMHA establishes a similar mandate. The language of the nondiscrimination provision creates a required—not preferred—prohibition against discrimination, and, as does the Boren Amendment, conditions federal funding on compliance.<sup>231</sup>

A § 1983 remedy also may be denied if the underlying statute is too vague to be enforced. In both *Wright* and *Wilder*, the Court found that the statutes were sufficiently clear.<sup>232</sup> Both cases involved statutes requiring, in part, that

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of noncompliance orders, civil suits, and criminal penalties," and also contained two private enforcement provisions. *Id.* Regarding *Smith*, the *Wilder* Court explained that the "elaborate" scheme in question "included local administrative review and culminated in a right to judicial review." *Id.*

225. *See id.* at 510, 519.

226. 451 U.S. 1 (1981).

227. *See id.* at 19. The Court explained that the Developmentally Disabled Assistance and Bill of Rights Act

is a mere federal-state funding statute. The explicit purposes of the Act are simply "to assist" the States through the use of federal grants to improve the care and treatment of the mentally retarded. Nothing in either the "overall" or "specific" purposes of the Act reveals an intent to require the States to fund new, substantive rights. Surely Congress would not have established such elaborate funding incentives had it simply intended to impose absolute obligations on the States.

*Id.* at 18 (citations omitted).

228. *Id.* at 22-23.

229. *See Wright v. City of Roanoke Redev. & Hous. Auth.*, 479 U.S. 418, 420 (1987).

230. *Wilder*, 496 U.S. at 512.

231. *See supra* text accompanying notes 123-27.

232. *See Wilder*, 496 U.S. at 519-520; *Wright*, 479 U.S. at 430-32.

states act reasonably,<sup>233</sup> a more ambiguous obligation than ADAMHA's clear prohibition of discrimination. The *Wilder* Court noted that a grant of some discretion does not render a provision unenforceable: a state must still act within certain parameters, and courts have enough expertise to evaluate compliance with the statute's requirements.<sup>234</sup> The *Wright* and *Wilder* Courts looked to the statutes' respective regulations for guidance in construing "reasonable" state action.<sup>235</sup> By contrast, ADAMHA's nondiscrimination provision does not require explication of "reasonableness," thus there is no vagueness hurdle.

Recently, however, the Court in *Suter v. Artist M.*<sup>236</sup> refused to permit a § 1983 action under a spending power statute, the Adoption Assistance and Child Welfare Act. As in *Wright* and *Wilder*, the statute in *Suter* required reasonable state action in a decision to remove a child from her home.<sup>237</sup> The Court compared the provision in *Suter* to that in *Pennhurst*, because both are spending power statutes,<sup>238</sup> explaining that when Congress conditions federal funding on compliance with a certain requirement it must do so "unambiguously."<sup>239</sup> In this case, however, the Court did not find that the statute, its regulations, or its legislative history provided any guidance in defining "reasonable"<sup>240</sup> and thus concluded that the reasonableness requirement did not confer an enforceable right.

The ADAMHA nondiscrimination provision, however, creates a clear obligation for the states. As noted earlier, the language does not mandate that states act reasonably, rather that they absolutely refrain from discrimination. Further, to the extent that ambiguity might be posited as a problem, guidance in interpretation can be gleaned from caselaw involving similar civil rights statutes.<sup>241</sup> The legislative history also lends insight into the statute's parameters, indicating congressional understanding of pregnancy discrimination in drug treatment programs and the extent of congressional willingness to change the status quo.<sup>242</sup> A court will have many sources of guidance in interpreting the ADAMHA nondiscrimination provision, thereby allowing it to entertain § 1983 actions.

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233. See *Wilder*, 496 U.S. at 519; *Wright*, 479 U.S. at 430.

234. *Wilder*, 496 U.S. at 519-20.

235. *Id.* at 507-08, 519 n.17; *Wright*, 479 U.S. at 431-32.

236. 112 S. Ct. 1360 (1992).

237. *Id.* at 1367.

238. See *id.* at 1366. Article I, § 8 of the Constitution contains the spending power, which provides that "Congress shall have Power To . . . provide for the . . . general Welfare of the United States." U.S. CONST. art. I, § 8, cl. 1.

239. *Suter*, 112 S. Ct. at 1366 (quoting *Pennhurst State Sch. v. Halderman*, 451 U.S. 1, 17 (1981)).

240. *Id.* at 1368-69.

241. For a discussion of statutes offering substantive guidance in interpreting ADAMHA's nondiscrimination provision, see *infra* notes 291-310 and accompanying text (Title VII and § 504).

242. See H.R. REP. No. 546, 102nd Cong., 2d Sess. 138 (1992) (explaining that although the statute does not require treatment on demand, pregnant women must "be afforded preferential treatment in admission to treatment programs, and . . . interim services . . . while they are awaiting admission to treatment").

### C. Identifying Potential Defendants

In addition to establishing their right to bring a cause of action, plaintiffs must identify the appropriate defendants in their cases. The ADAMHA nondiscrimination provision does not expressly state which entity or entities (states, municipalities, and/or treatment programs) are bound by its mandate. Rather, the language ensures that "[n]o person shall . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded" by ADAMHA block grants.<sup>243</sup> The enforcement section may be triggered, however, when "a State, or an entity [that receives ADAMHA funding] . . . has failed to comply."<sup>244</sup> Therefore, both states<sup>245</sup> and treatment programs receiving federal funding are bound by the nondiscrimination provision and may be subject to suit.

While a suit against a specific program may secure relief for a particular plaintiff, a broader action against the state—either instead of, or as a supplement to, the action against the program—may offer two advantages with respect to injunctive relief.<sup>246</sup> Because the state has access to a continuum of resources and can identify appropriate alternatives, a suit against a state may provide relief where a particular program could not accommodate the plaintiff. Additionally, the state, unlike an individual program, may be able to bring about large-scale change in treatment accessibility.

The Act's statutory scheme and legislative history support placing the ultimate burden of providing access to treatment on the states. The Act places states in charge of providing services to pregnant women.<sup>247</sup> Where a particular clinic can not accommodate a pregnant woman, the burden shifts to the state to find an alternative location or to provide the woman with interim services within forty-eight hours.<sup>248</sup> In addition, the general approach of the statute provides for disbursements to states, which then determine, within certain parameters, the individual recipients of the federal funding.<sup>249</sup>

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243. 42 U.S.C.A. § 300x-57(a)(2) (West Supp. 1993).

244. *Id.* § 300x-57(b)(1).

245. Specifically, the suit would be brought against the head of the state agency responsible for disbursing federal funding. Where a clinic controverts state policy, however, and discriminates by categorically excluding pregnant women, a suit against the clinic itself would be appropriate. The state, however, may also be liable in such instances if it knowingly provides federal funds to a discriminatory program. Under such a theory, a municipality might be liable if it were serving as an intermediary between the state and a treatment program, and knowingly passed along funds to a clinic that discriminates against pregnant women. It is important to note that if a § 1983 claim is brought against a municipality, the plaintiff will have to show that the alleged violation was an official policy or custom of the defendant municipality. *See Monell v. New York City Dep't of Social Servs.*, 436 U.S. 658, 690-91 (1978).

246. For a more detailed discussion of the availability of injunctive and damage remedies, see *infra* notes 258-77 and accompanying text.

247. 42 U.S.C.A. § 300x-27(a) (West Supp. 1993) (listing duties of state grantees in providing services to pregnant women).

248. *Id.* § 300x-27(b)(2).

249. *Id.* § 300x-21.



Further, the legislative histories of the ADAMHA Reorganization Act and its predecessor demonstrate congressional intent to place an obligation squarely on the states. In the debate over the Act, Representative Henry Waxman explained that ADAMHA was designed to make the states “responsible—as a condition of receiving block grants funds—for assuring the availability of appropriate care.”<sup>250</sup> The intent of the 1981 Congress that first created ADAMHA is especially enlightening on this point. The block grant program was created in the first year of the Reagan Administration<sup>251</sup> in an effort to restore state control and foster versatile approaches to solving national problems.<sup>252</sup> One Senate report explained that “the general effect will be to return basic control and responsibility to the State level.”<sup>253</sup>

#### D. Obtaining Relief

In addition to identifying defendants, plaintiffs bringing suit under ADAMHA’s nondiscrimination provision must identify the nature of the relief they are seeking. The Supreme Court in *Guardians Association v. Civil Service Commission of New York*<sup>254</sup> explained that the issue of relief is “analytically distinct” from the initial question of whether a plaintiff may bring a private cause of action.<sup>255</sup> Although a court may have already determined that a plaintiff can bring her claim, it still must address whether it should award injunctive relief and/or damages. A damage remedy involves monetary recovery. An injunctive remedy, at a minimum, enables a particular plaintiff to enter treatment, and, more extensively, requires some restructuring of the treatment delivery system in order to better accommodate pregnant drug-addicted women. The enforcement provisions of the ADAMHA nondiscrimination clause only address remedies available where the Attorney General enforces the statute in federal court, allowing for “such relief as may be appropriate, including injunctive relief.”<sup>256</sup> Because the statute does not explicitly provide for private enforcement, “it is hardly surprising that Congress also said nothing about the applicable remedies for an implied right of action.”<sup>257</sup> The civil rights statutes containing nondiscrimination language similar to that of ADAMHA again offer some guidance, this time in determining the proper scope of relief.

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250. 138 CONG. REC. H5702 (daily ed. July 1, 1992) (statement of Rep. Waxman).

251. DAVID GATES, NATIONAL HEALTH LAW PROGRAM, AN OVERVIEW OF FEDERAL FUNDING PROGRAMS FOR THE PREVENTION AND TREATMENT OF ALCOHOLISM AND DRUG DEPENDENCY 20 (1990) (on file with author).

252. See S. REP. No. 139, 97th Cong., 1st Sess. 871 (1981) (“States are encouraged to seek the resolution of health problems according to their own needs, even if such resolution leads them to models or approaches completely different from those formerly sponsored by the federal government.”).

253. *Id.*

254. 463 U.S. 582 (1983).

255. *Id.* at 595 (plurality opinion) (quoting *Davis v. Passman*, 442 U.S. 228, 239 (1979)).

256. 42 U.S.C.A. § 300x-57(b)(2) (West Supp. 1993).

257. *Franklin v. Gwinnett County Pub. Sch.*, 112 S. Ct. 1028, 1035 (1992).

In addressing the availability of injunctive relief under Title VI, the *Guardians* Court explained that such a remedy may better meet the goals of a spending power statute than would the termination of funding, even where the latter remedy is explicitly allowed by the language of the statute.<sup>258</sup> The Court noted that the legislative history of Title VI revealed the ultimate goal of the statute: elimination of discrimination. "The remedy of termination of assistance was regarded as 'a last resort, to be used only if all else fails,' because 'cutoffs of Federal funds would defeat important objectives of Federal legislation, without commensurate gains in eliminating racial discrimination or segregation.'"<sup>259</sup> This same rationale applies to pregnancy discrimination in drug treatment programs because the goal of expanding treatment opportunities for pregnant women would not be met where clinics deemed to be discriminatory only suffered a loss of funding. In fact, such a response could exacerbate the problem.

The *Guardians* Court also addressed money damages, limiting the availability of such relief to instances of intentional (or facial) discrimination.<sup>260</sup> This approach was based on the nature of the relationship between the federal government and entities receiving grants pursuant to the Spending Clause. The Court explained that "the receipt of federal funds under typical Spending Clause legislation is a consensual matter: the State . . . weighs the benefits and burdens before accepting the funds and agreeing to comply with the conditions attached to their receipt."<sup>261</sup> Consequently, monetary awards may be available where a grant recipient is aware of its obligation under the program in question and knowingly breaches that requirement.<sup>262</sup> Because the exclusion of pregnant women from drug treatment programs generally is an explicit policy,<sup>263</sup> most ADAMHA defendants will be facing challenges to intentional discrimination. Those programs or states found to have committed intentional discrimination against pregnant women may be liable for damages.

In a recent Title IX case, *Franklin v. Gwinnett County Public Schools*,<sup>264</sup> the Court reaffirmed its broad approach to injunctive relief and its much narrower view of damages. Regarding injunctive relief, the Court explained that "[t]he general rule . . . is that absent clear direction to the contrary by Congress, the federal courts have the power to award any appropriate relief in a cognizable cause of action brought pursuant to a federal statute."<sup>265</sup> Accordingly, the *Franklin* Court found that the Title IX plaintiff could rely on

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258. *Guardians*, 463 U.S. at 601-02 (plurality opinion).

259. *Id.* at 601 (quoting 110 CONG. REC. H6544, 6546 (1964)).

260. *Id.* at 597.

261. *Id.* at 596.

262. *Id.* at 597. Injunctive relief, however, is the standard remedy under Title VI. See, e.g., *Regents of the Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978).

263. See *supra* notes 22-29 and accompanying text.

264. 112 S. Ct. 1028 (1992).

265. *Id.* at 1035.

the "traditional presumption in favor of all appropriate relief."<sup>266</sup> Similarly, an ADAMHA plaintiff may ask the federal courts to exercise broad powers in determining the extent to which treatment regimens must change to accept pregnant women.

The *Franklin* Court followed earlier decisions that limited awards of damages to intentional discrimination.<sup>267</sup> The Court chose to award damages in this case, where a student had brought suit against a school district for sexual harassment by a teacher.<sup>268</sup> Emphasizing the importance of providing meaningful relief, the Court observed that prospective injunctive relief would be worthless because the teacher was no longer employed at the school and the plaintiff had since graduated.<sup>269</sup> This rationale similarly may allow for damage recoveries in ADAMHA suits where plaintiffs cannot avail themselves of injunctive relief and where intent to discriminate can be shown. Individual plaintiffs and a portion of plaintiffs in ADAMHA class action suits (including the named class representatives), likely will not still be pregnant when a judgment is rendered. Therefore, as in *Franklin*, such plaintiffs will not be able to avail themselves of an injunction admitting them into treatment and will only benefit from an award of money damages. Unlike *Franklin*, however, where injunctive relief was not awarded because the teacher had left the district, named plaintiffs in ADAMHA class action suits will also be able to secure injunctive relief because the programs will be able to offer treatment in the future to pregnant women.<sup>270</sup>

One final issue remains on the subject of remedies. Because states may be implicated as defendants, the question inevitably arises as to whether the Eleventh Amendment<sup>271</sup> proscribes damage awards against them. As noted above, while injunctive relief may benefit many members of a certified class, some plaintiffs likely will no longer be pregnant and will be unable to benefit from injunctive relief (unless they again become pregnant and are still seeking drug treatment).<sup>272</sup>

The Supreme Court has held that states are immune from damage actions unless they waive their immunity and consent to suit.<sup>273</sup> Under the Civil

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266. *Id.* at 1036.

267. *See id.* at 1036-37. The Court noted that if Congress had intended to further limit damage awards, it could have done so in the Civil Rights Remedies Equalization Act of 1986 or the Civil Rights Restoration Act of 1987. Since Congress did not articulate any such intent, the Court preserved the right to recover damages for intentional violations. *Id.*

268. *Id.* at 1038.

269. *Id.* An award of back pay also would be useless. *Id.*

270. Plaintiffs could be separated into two subclasses—one receiving only injunctive relief and one eligible for damages. FED. R. CIV. P. 23(c)(4)(B) ("When appropriate a class may be divided into subclasses and each subclass treated as a class").

271. U.S. CONST. amend. XI.

272. "For people in *Bivens*' shoes [whose constitutionally protected interests have been violated], it is damages or nothing." *Bivens v. Six Unknown Named Agents*, 403 U.S. 388, 410 (1971) (Harlan, J., concurring)

273. *Edelman v. Jordan*, 415 U.S. 651, 673-78 (1974) (invalidating order requiring payment of state funds as compensation to those denied benefits under challenged scheme).

Rights Remedies Equalization Act,<sup>274</sup> however, a plaintiff can recover damages from a defendant state in a suit brought directly under the ADAMHA provision. The amendment abrogates states' Eleventh Amendment immunity under Title IX, § 504, Title VI, the Age Discrimination Act, and "the provisions of any other Federal statute prohibiting discrimination by recipients of Federal financial assistance."<sup>275</sup> Since ADAMHA falls under the description in the last clause of the amendment, a plaintiff suing a state will be able to rely on this explicit abrogation of damage immunity and seek both injunctive relief and damages. This abrogation, however, does not apply to suits brought against the state under § 1983. Courts will presume that states retain immunity under § 1983 because that immunity is not clearly waived in the Civil Rights Remedies Equalization Act.<sup>276</sup> This limitation applies in both state and federal court.<sup>277</sup>

Plaintiffs bringing suit directly under ADAMHA will be able to seek both injunctive and damage remedies, although the availability of damages may be limited to certain types of actions (challenges to intentional discrimination) and parties (plaintiffs who are no longer pregnant and who therefore can not avail themselves of injunctive relief). Plaintiffs suing under § 1983 will be limited to injunctive relief. The value of injunctive relief, however, should not be underestimated. Injunctions address the problem specifically targeted by the statute—pervasive exclusion of pregnant women from drug treatment. They also hold the potential for securing large-scale future change.

Damages also serve a number of crucial functions. They compensate the victims of discrimination and serve as a punishment for defendants' past acts, as well as a deterrent against future acts of discrimination. The deterrence function may be the most important for the class of pregnant women seeking treatment. Since treatment programs exclude pregnant women in part due to concerns regarding liability, the threat of ADAMHA damage actions may eliminate any perceived monetary benefit from discriminatory policies. Plaintiffs seeking damages, however, may want to weigh the benefits of such actions against the already short supply of funding for drug treatment programs. This short supply of funding may counsel plaintiffs to place a reasonable ceiling on their requests for damages.

The above discussion regarding causes of action, potential defendants, and remedies highlights some important strategic considerations that ADAMHA plaintiffs will face. For example, while a plaintiff may have claims for a private action both under ADAMHA directly and under § 1983, § 1983 offers

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274. 42 U.S.C. § 2000d-7 (1988). This amendment, abrogating states' immunity, was passed in reaction to the Supreme Court's decision in *Atascadero State Hospital v. Scanlon*, 473 U.S. 234 (1985), which required that Congress "unequivocally" abrogate the states' Eleventh Amendment immunity. *Id.* at 243.

275. 42 U.S.C. § 2000d-7 (a)(1) (1988).

276. See *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 (1985).

277. See *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 64, 66 (1989) (holding that states are not persons under § 1983 for purposes of damage actions and thus retain immunity under § 1983).

more latitude for bringing such actions. However, while § 1983 also provides for attorney's fees, it does not allow suits against private actors, nor does it enable plaintiffs to seek damages from the state. Further, damages may only be available for certain types of plaintiffs, and only where intent can be shown. Therefore, plaintiffs challenging pregnancy discrimination in drug treatment programs will need to identify and analyze the scope and nature of relief they are seeking in order to plan their litigation strategy appropriately.

#### IV. THE SUBSTANTIVE REQUIREMENTS OF THE NONDISCRIMINATION PROVISION

In order for a plaintiff to recover under ADAMHA's nondiscrimination provision, she must show that the defendant has violated the substantive requirements of the Act. This section will examine what the statute requires. In other words, what constitutes pregnancy discrimination in the drug treatment context? After developing a legal standard, including a delineation of the prima facie case and affirmative defenses, this section will apply the standard to the current picture of drug treatment to determine the viability of plaintiffs' and defendants' claims.

##### *A. Presenting the Prima Facie Case and Affirmative Defenses*

###### *1. The Prima Facie Case*

A plaintiff will have made a prima facie case of facial or intentional discrimination under ADAMHA where she can show that she was explicitly excluded from treatment due to her pregnancy (for example, that the program has a written policy excluding pregnant women), or that particular burdens were placed on her simply because she was pregnant (such as insurance requirements or limitations on admittance based on the stage of her pregnancy). The Supreme Court has explained that a policy is facially discriminatory where it treats members of one group differently because they are identified as part of that group.<sup>278</sup> A woman who is treated differently simply because she is pregnant has been subjected to facial discrimination. This Article's development of the prima facie case will focus on intentional discrimination because the evidence indicates that this is the type of exclusion pregnant drug-addicted women generally face.<sup>279</sup>

In apparent contradiction to the guidelines set forth by the Supreme Court, a state appellate court in New York held that excluding women simply because they are pregnant is not facially discriminatory under the state's public

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278. *City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978).

279. *See supra* notes 22-29 and accompanying text.

accommodations law.<sup>280</sup> In *Elaine W. v. Joint Diseases North General Hospital*, the first case challenging pregnancy discrimination in substance abuse services, the court found that such a practice was not discriminatory, but rather was "based upon sound medical judgment."<sup>281</sup> The court explained that women were not the only group to be excluded, because "psychotic patients" were also denied admission due to the hospital's inability to provide sufficient medical care, and thus only medical judgment, not discrimination, was involved.<sup>282</sup> This analysis, however, was rejected by the New York Court of Appeals, which held that North General's blanket exclusion of pregnant women constituted discrimination.<sup>283</sup> The New York Court of Appeals adhered to the U.S. Supreme Court's approach in *International Union, UAW v. Johnson Controls*<sup>284</sup> in defining facial discrimination. The Supreme Court in *Johnson Controls* explained that, "[w]hether [a] practice involves . . . explicit facial discrimination does not depend on why the employer discriminates but rather on the explicit terms of the discrimination."<sup>285</sup> Justifications may be utilized as affirmative defenses but they are not sufficient to support a finding that a policy is not discriminatory.

While most cases of pregnancy discrimination in drug treatment involve instances of facially discriminatory policies, those programs that engage in covert, intentional discrimination or use policies that disparately affect pregnant women also may be vulnerable under ADAMHA. This issue is especially relevant because programs that currently utilize overt policies of discrimination may, as a response to ADAMHA litigation or related pressure, alter their approaches to more subtle means of excluding pregnant women. While the development of a substantive doctrine for addressing these forms of discrimination is beyond the scope of this article, the judicial approaches under other statutes could provide some guidance.<sup>286</sup>

## 2. Is an Affirmative Defense Available?

Because an ADAMHA plaintiff generally will satisfy the prima facie case simply by showing that she has been subjected to facial discrimination, drug treatment programs who explicitly differentiate between pregnant women and other individuals seeking treatment will have to resort to affirmative defenses

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280. *Elaine W. v. Joint Diseases N. Gen. Hosp.*, 580 N.Y.S.2d 246 (App. Div. 1992).

281. *Id.* at 247. The trial court granted summary judgment on this basis. *See id.*

282. *Id.* at 248.

283. *Elaine W. v. Joint Diseases N. Gen. Hosp.*, 613 N.E.2d 523, 524 (N.Y. 1993).

284. 499 U.S. 187 (1991).

285. *Id.* at 199.

286. *See, e.g., Texas Dep't of Community Affairs v. Burdine*, 450 U.S. 248 (1981) (clarifying Title VII disparate treatment doctrine); *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973) (outlining Title VII disparate treatment doctrine); *Griggs v. Duke Power Co.*, 401 U.S. 424 (1971) (establishing a disparate impact approach under Title VII). Although the Supreme Court overruled the *Griggs* test in *Wards Cove Packing Co. v. Atonio*, 490 U.S. 642, 658-61 (1989), Congress reestablished the *Griggs* standard in the Civil Rights Act of 1991, 42 U.S.C.A. § 2000e-2(k) (West Supp. 1993).

to justify their policies. The two primary reasons likely to be put forth by treatment programs for excluding pregnant women are the inability to provide medically safe treatment and the fear of tort liability.<sup>287</sup>

The ADAMHA Reorganization Act is silent regarding the availability of affirmative defenses. The statute's treatment of the issue of pregnancy discrimination is limited to a brief proscription of such conduct in the nondiscrimination clause. Similarly, the legislative history does not shed any light on this matter. Rather, as noted earlier, Congress' discussion focused on the severe treatment crisis for pregnant women.<sup>288</sup> This scarcity of information is not surprising, however, since Congress did not even address the question of private causes of action under ADAMHA.<sup>289</sup>

The question of affirmative defenses may be explored by examining approaches used under similar civil rights statutes. The first question, then, in analyzing an affirmative defense under ADAMHA's nondiscrimination provision, is whether similar civil rights statutes ever allow a defendant to put forth justifications for discrimination and, if so, under what circumstances. In some cases, statutes proscribing discrimination explicitly provide for exceptions. For example, under Title IX, Congress listed a number of contexts in which recipients of federal funds could distinguish upon the basis of sex, including military training, social organizations and voluntary youth service organizations, parent-child events at educational institutions and scholarships awarded in "beauty pageants."<sup>290</sup> The ADAMHA Reorganization Act, however, does not provide any statutory exceptions. The Title IX provision suggests that Congress knows how to provide exceptions when it wants to do and that courts should not permit affirmative defenses unless specifically provided for by statute.

In some circumstances, however, Congress and the Court have allowed defendants more flexibility by creating less definite obligations under federal civil rights statutes. For example, under § 504 of the Rehabilitation Act, a federally funded entity need only make "reasonable modifications" for a person with disabilities.<sup>291</sup> Similarly, under Title VII, an employer challenged with

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287. See, e.g., *Elaine W. v. Joint Diseases N. Gen. Hosp.*, 580 N.Y.S.2d 246, 247 (App. Div. 1992) (noting hospital claim that it is not equipped to provide obstetrical care); *Hemphill*, *supra* note 23, at 8 (observing that programs claim they are not equipped to provide obstetrical and gynecological care); *Miller*, *supra* note 108, at 8 (stating that pregnant women who undergo drug treatment are perceived by insurers as "high-risk" and "more likely to sue the facility"); *Polsky*, *supra* note 23, at 6 (explaining that women are generally excluded due to "liability and costs associated with providing medical and child care"); *Tracy et al.*, *supra* note 48, at 7 (noting that programs generally refuse to treat pregnant women because of fear of liability and "perceived medical complications").

288. See *supra* notes 153-55 and accompanying text.

289. See *supra* text accompanying note 257.

290. 20 U.S.C. § 1681(a)(1)-(9) (1988).

291. *Alexander v. Choate*, 469 U.S. 287, 300 (1985). The actual language of § 504's prohibits discrimination against an "otherwise qualified handicapped individual . . . solely by reason of her or his handicap." 29 U.S.C. § 794(a). The Court has noted that

the question of who is "otherwise qualified" and what actions constitute "discrimination" under the section would seem to be two sides of a single coin; the ultimate question is the extent to which a grantee is required to make reasonable modifications in its programs for the needs of

facial discrimination may make distinctions on the basis of "religion, sex, or national origin" where it is a "bona fide occupational qualification."<sup>292</sup>

The § 504 and Title VII doctrines provide useful models for interpreting ADAMHA's nondiscrimination provision. Unlike the rigid statutory scheme in Title IX, they are based on general statutory mandates and courts primarily create exceptions through judicial interpretation.<sup>293</sup> Moreover, both bodies of law acknowledge the need for realistic compromises, avoiding the danger of imposing absolutes in complex environments. Section 504 requires only "reasonable accommodation," because financial and physical practicalities may preclude infinite accommodations for people with disabilities.<sup>294</sup> Similarly, Title VII's BFOQ standard, while creating a narrow exception, allows distinctions to be made in the workplace where "real differences" exist.<sup>295</sup>

### a. *The Section 504 Model*

In *Southeastern Community College v. Davis*,<sup>296</sup> the Court examined for the first time a defendant's obligation under § 504. In *Davis*, a college nursing program had denied entrance to the respondent because of her hearing disability. The Court found the denial lawful, holding that § 504 did not

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the handicapped.

*Alexander*, 469 U.S. at 299 n.19.

292. 42 U.S.C. § 2000e-2(e)(1) (1988).

293. While the Pregnancy Discrimination Act (PDA) under Title VII also offers a tool for interpreting pregnancy discrimination, this comparison would be inapposite here because of its specific nature. Unlike the general proscriptions under Title VII's BFOQ standard (of which the PDA is a part) and under § 504, the PDA offers detailed guidelines regarding treatment of pregnant women in the workplace. The PDA added subsection (k) to § 701, providing definitions for Title VII. It provides:

The terms "because of sex" or "on the basis of sex" include, but are not limited to, because of or on the basis of pregnancy, childbirth, or related medical conditions; and women affected by pregnancy, childbirth, or related medical conditions shall be treated the same for all employment-related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected but similar in their ability or inability to work, and nothing in 2000e-2(h) of this title shall be interpreted to permit otherwise. This subsection shall not require an employer to pay for health insurance benefits for abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion: *Provided*, That nothing herein shall preclude an employer from providing abortion benefits or otherwise affect bargaining agreements in regard to abortion.

42 U.S.C. § 2000e(k) (1988). Thus, the doctrine surrounding the PDA relies more on the extensive language of the statute than on judicial interpretations.

294. Justice Marshall in *Alexander* noted Congress' perception of the nature of discrimination against people with disabilities as "not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect." *Alexander*, 469 U.S. at 295. He went on to note that federal agencies and commentators view "discrimination against the handicapped [as] primarily the result of apathetic attitudes rather than affirmative animus." *Id.* at 296. Similarly, the exclusion of pregnant women from drug treatment programs does not fall into the traditional category of "affirmative animus." Pregnant women are excluded from treatment because of perceived insufficiencies in medical support and fears of liability. Nevertheless, the exclusion is part of a larger phenomenon in which pregnant women are blamed for their addiction and made the objects of prosecutions and other coercive state-sponsored measures. Thus, while the immediate cause for excluding pregnant women from drug treatment may not be motivated by "affirmative animus," the problem seems to go beyond "benign neglect."

295. Although these flexible standards present opportunities for misapplication, they also provide leeway for important compromises.

296. 442 U.S. 397 (1979).



require the college to disregard her disability or to make “substantial modifications” in its program to accommodate her.<sup>297</sup> The Court cited “undue financial and administrative burdens upon [the] State” as relevant considerations.<sup>298</sup> It also noted, however, that “situations may arise where a refusal to modify an existing program might become unreasonable and discriminatory.”<sup>299</sup>

Six years later, in *Alexander v. Choate*,<sup>300</sup> the Court provided additional guidance in interpreting § 504. The Court explained that § 504 might, in some circumstances, require more than the provision of identical services to people with disabilities to assure meaningful access to a federal grantee’s program.<sup>301</sup> The Court noted that § 504 “is intended to encompass the concept of equivalent, as opposed to identical, services,”<sup>302</sup> but does not require states “to alter [their] definition of [a] benefit being offered simply to meet the reality that the handicapped have greater . . . needs.”<sup>303</sup> Applying this standard, the Court denied relief to plaintiffs seeking additional days of Medicaid inpatient hospital coverage for people with disabilities, explaining that plaintiffs would benefit meaningfully from the state’s Medicaid package. Accordingly to *Alexander*, § 504 requires a recipient of federal funds to ensure that people with disabilities have some access to their programs, although the extent of accommodation may be limited by the entity’s available resources.

#### b. *The Title VII Model*

The BFOQ exception under Title VII should also inform the obligations of federally funded drug treatment programs under ADAMHA.<sup>304</sup> While employers may make sex-based distinctions based upon a “bona fide occupational qualification,” the Court in *Johnson Controls* explained the narrow purview of this defense, emphasizing the need for an “objective, verifiable requirement”<sup>305</sup> rather than “an employer’s idiosyncratic requirement.”<sup>306</sup> Under Title VII, the question is whether a change in the

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297. *Id.* at 405.

298. *Id.* at 412.

299. *Id.* at 413.

300. 469 U.S. 287 (1985).

301. *Id.* at 305-06.

302. *Id.* at 305 n.26 (quoting 45 C.F.R. pt. 84 app. A at ¶ 6 (1984)).

303. *Id.* at 303.

304. “Under § 703 (e)(1) of Title VII, an employer may discriminate on the basis of ‘religion, sex, or national origin in those certain instances where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise.’” *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 200 (1991) (quoting 42 U.S.C. § 2000e-2(e)(1) (1988)).

305. *Id.* at 201.

306. *Id.*; see also *Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1084 n.13 (1983) (stating that sex is not a verifiable indicator of longevity); *City of L.A. Dep’t of Water & Power v. Manhart*, 435 U.S. 702, 711 (1978) (same); *Dothard v. Rawlinson*, 433 U.S. 321, 332-33 (1977) (stating that height and weight requirements are not an appropriate indicator of strength).

employer's particular practice would threaten the "essence of the business."<sup>307</sup> If a change does not present such a threat, the employer must alter its policy and eliminate the facial discrimination.<sup>308</sup>

The Court in *Johnson Controls* proceeded to address two defenses that do not qualify as threats to the essence of an operation. First, the Court noted that fear of tort liability will not save a defendant from her obligation under Title VII. "When it is impossible . . . to comply with both state and federal requirements, [the] Court has ruled that federal law preempts that of the States."<sup>309</sup> Second, the Court stated that extra cost, unless prohibitive, does not provide an affirmative defense to pregnancy discrimination under Title VII. "Congress considered at length the considerable cost of providing equal treatment of pregnancy and related conditions, but made the 'decision to forbid special treatment of pregnancy despite the social costs associated therewith.'"<sup>310</sup> Although Title VII's BFOQ standard allows defendants some latitude where elimination of a discriminatory policy would threaten the business, the types of justifications that a court will accept are fairly circumscribed.

### c. *An Affirmative Defense Under ADAMHA*

In examining the § 504 and Title VII doctrines to develop an affirmative defense under ADAMHA's nondiscrimination provision, a central concern emerges. Both approaches focus on the ability of a putative defendant to respond to the needs of a plaintiff without threatening its own ability to function. Section 504 requires reasonable modifications, limited by the defendant's resources.<sup>311</sup> Similarly, Title VII allows a defendant to discriminate where a change in such a practice would threaten the "essence" of the operation.<sup>312</sup>

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307. *Johnson Controls*, 499 U.S. at 203.

308. While the BFOQ paradigm ostensibly provides an exception to Title VII's negative proscription against discrimination, in contrast to the more affirmative "reasonable accommodation" standard under § 504, there are some circumstances in which an employer under Title VII similarly will be required to make an accommodation. Because the Court has noted that BFOQ is an objective standard, merely idiosyncratic requirements put forth by an employer to justify discrimination (i.e. practices that are not bona fide occupational requirements) will be rejected. In such circumstances, the employer will be required to change its operations and accommodate the employee(s) in question.

309. *Johnson Controls*, 499 U.S. at 209. In addition, the Court in *Johnson Controls* left open the question of whether a defendant could allege that the costs of defending a tort liability suit would endanger its ability to function. *Id.* at 210. For an analysis of whether fear of liability is a valid defense for ADAMHA defendants, see *infra* notes 357-64 and accompanying text.

310. *Johnson Controls*, 499 U.S. at 210 (quoting *Arizona Governing Comm. v. Norris*, 463 U.S. 1073, 1085 n.14 (1983) (Marshall, J., concurring)).

311. See *supra* notes 296-303 and accompanying text.

312. See *supra* notes 304-310 and accompanying text. While the BFOQ standard applies to facial discrimination cases, an ADAMHA plaintiff bringing suit for disparate impact discrimination may be able to rely on the "business necessity" test under Title VII. See *Griggs v. Duke Power Co.*, 401 U.S. 424, 429-31 (1971).

An analogous requirement under ADAMHA, then, would allow pregnancy discrimination only where the elimination of such a practice would affect the integrity of a defendant's program. This Article suggests the following standard: Pregnancy discrimination under ADAMHA is permissible only where it is necessary to achieve a fundamental objective of the program. Under the first prong of this test, fundamental objectives include the medically safe treatment of clients<sup>313</sup> and the avoidance of any cost that jeopardizes the viability of the program.<sup>314</sup> Yet, a defendant will have to show more than an effort to satisfy one of these goals. Under the second part of the standard, a defendant bears the burden (after the plaintiff has satisfied the *prima facie* case) of demonstrating that discrimination against pregnant women is necessary to meet its goal or goals. "Necessary" means that a policy can only be satisfied through the means used—that no reasonable alternatives exist.

An analogous standard was put forth by the New York Court of Appeals in a case brought under the state's public accommodations law. In *Elaine W. v. Joint Diseases North General Hospital*,<sup>315</sup> plaintiffs challenged blanket exclusions of pregnant women from detoxification programs. The defendant hospital asserted a medical justification, claiming that it could not treat pregnant women because it did not have an obstetrical staff or a license to provide such services.<sup>316</sup> The court accepted as legitimate the defendant's stated goal of offering medically safe treatment,<sup>317</sup> but the court held that a defendant could not invoke this objective to justify blanket exclusions unless the exclusions were always necessary to provide safe treatment, or, in the alternative, unless the defendant could not discern in advance which women might be treated safely.<sup>318</sup> The court stated that the defendant would have to prove that the blanket exclusions were medically warranted in all cases at trial.<sup>319</sup>

Importantly, the court stated that the defendant could not carry its burden "by showing that some, or even many, pregnant women should not be treated for substance abuse without the availability of immediate on-site obstetrical services. . . . '[E]ven a true generalization about the class is an insufficient reason for disqualifying an individual to whom the generalization does not apply.'"<sup>320</sup> Similarly, under ADAMHA a defendant asserting a medical defense would be required to prove that the generalization supporting its

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313. Under a related test for pregnancy discrimination in substance abuse treatment, the New York Court of Appeals identified medically warranted exclusions as acceptable. See *Elaine W. v. Joint Diseases N. Gen. Hosp. Inc.*, 613 N.E.2d 523, 524 (N.Y. 1993).

314. This objective is based on the notion that discrimination is justified if eliminating it would threaten the essence of the operation. See *Johnson Controls*, 499 U.S. at 203.

315. 613 N.E.2d 523 (N.Y. 1993).

316. *Id.* at 524.

317. *Id.* at 525.

318. See *id.* at 524.

319. *Id.* at 526.

320. *Id.* at 526 (quoting *City of L.A. Dep't of Water & Power v. Manhart*, 435 U.S. 702, 708 (1978)).

blanket exclusion of pregnant women always applies, or, in the alternative, that there are no other means to screen out unsafe cases.<sup>321</sup>

This factual inquiry, as part of the "necessary" prong, serves as an important check on vague, generalized claims by ADAMHA defendants that blanket exclusions are medically warranted. While courts may be tempted to adopt such justifications without analysis, these defenses require a careful factual evaluation, especially in light of the history of judicial reliance on medical reasons to justify discrimination. For example, as late as the 1960s, unexamined assertions of "medical judgment" were used to justify racial segregation in health care facilities.<sup>322</sup> Quite recently, the lower court in *Elaine W.* granted summary judgment for the defendants based on unexamined medical justifications that rationalized blanket exclusions of pregnant women from detoxification programs.<sup>323</sup> Under the proposed standard, while medically warranted blanket exclusions theoretically could be accepted under ADAMHA, the question remains whether such an exclusion could be factually supported under the second prong of the ADAMHA analysis.

#### B. *Analyzing the Affirmative Defenses*

This Section will analyze the viability of affirmative defenses under the ADAMHA nondiscrimination provision. It will use the legal standard proposed above to evaluate the two primary types of defenses likely to be put forth by ADAMHA defendants: medical justification and fear of tort liability. Such affirmative defenses generally would fail in a suit under ADAMHA's nondiscrimination provision. Blanket exclusions of pregnant women are not necessary to preserve the medical integrity of drug treatment programs. Treatment for pregnant women does not generally differ greatly from that offered to other clients; it is possible to identify in advance those women who could not be treated safely without special provisions, such as on-site obstetrical care. Fear of tort liability is unsupported by both the facts and the

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321. Notably, a comparable standard to the one proposed in this article was accepted by the Supreme Court in the context of a BFOQ defense for age discrimination. In *Western Air Lines v. Criswell*, 472 U.S. 400 (1985), the Court examined the BFOQ defense under the Age Discrimination in Employment Act, which offers a parallel analysis to that under Title VII. *See id.* at 416. In adopting the lower court's standard, the Court first put forth a "necessary" prong, requiring that "[t]he job qualifications which the employer invokes to justify his discrimination must be reasonably necessary to the essence of his business." *Id.* at 413. The Court went on to explain that discrimination is only *reasonably necessary* where "the employer is compelled to rely on age as a proxy for the safety-related job qualifications validated in the first inquiry." *Id.* at 414. An employer may establish this contention through two means. First, "[t]he employer could establish that it 'had reasonable cause to believe, that is, factual basis for believing, that all or substantially all [persons over the age qualifications] would be unable to perform safely and efficiently the duties of the job involved.'" *Id.* (quoting *Usery v. Tamiami Trail Tours, Inc.*, 531 F.2d 224, 235 (5th Cir. 1976)). In the alternative, the employer could show that facially discriminating on the basis of age is necessary because it is "impossible or highly impractical" to deal with the older employees on an individualized basis." *Id.* (quoting *Usery*, 531 F.2d at 235).

322. *See, e.g., Wood v. Hogan*, 215 F. Supp. 53, 55-56 (W.D. Va. 1963).

323. *See Elaine W. v. Joint Diseases N. Gen. Hosp. Inc.*, 580 N.Y.S.2d 246 (App. Div. 1992).

law. This section will focus primarily on medical justifications, with a shorter review of the fear of liability defense, since medical justifications are more likely to be asserted in court.

### 1. Medical Defenses

Medical justifications put forth by treatment programs for excluding pregnant women may include concerns about the inappropriateness of a particular treatment approach for pregnant women and the unavailability of needed medical services (such as on-site obstetrical care).<sup>324</sup> Although the delivery of safe and appropriate treatment and the provision of ancillary medical services qualify as fundamental objectives under the first prong of the standard, the blanket exclusion of pregnant women is not necessary to meet these goals. Admitting pregnant women into drug treatment does not generally jeopardize the health and safety of the women or their fetuses, nor does it require full-time on-site obstetrical services. While there may be some exceptions to these propositions, they do not justify blanket exclusions. Individualized analyses of patients would provide a reasonable alternative, allowing treatment programs to identify those pregnant women who could not be safely treated.

In most cases, drug treatment approaches for pregnant women do not differ greatly from those for other clients. Detoxification, "therapeutically supervised withdrawal to abstinence over a short term,"<sup>325</sup> is usually the first stage of treatment,<sup>326</sup> and it may last for up to twenty-one days.<sup>327</sup> Except in cases of heroin addiction, pregnant women may safely undergo drug-free detoxification.<sup>328</sup> Although some researchers recommend hospitalization for pregnant women undergoing detoxification,<sup>329</sup> the need for medical supervision can generally be met if a non-hospital-based detoxification program provides hospital-based back-up care.<sup>330</sup> After detoxification, or as a first

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324. This analysis may be more crucial than that concerning fear of liability, because programs may be more likely to focus on medical justifications rather than admit to worries about liability. *See, e.g., Elaine W. v. Joint Diseases N. Gen. Hosp. Inc.*, 613 N.E.2d 523, 524 (N.Y. 1993) (defendant hospital justified exclusion based on insufficient medical facilities and staff).

325. TREATING DRUG PROBLEMS, *supra* note 6, at 16.

326. Heroin addiction presents a separate problem because methadone detoxification is not recommended for pregnant women. *See Michelle H. Allen, Detoxification Considerations in the Medical Management of Substance Abuse in Pregnancy*, 67 BULL. N.Y. ACAD. MED. 270, 273-74 (1991). Pregnant women, however, may safely undergo methadone maintenance. For a fuller discussion of methadone maintenance, in contrast to detoxification, see *infra* notes 338-45 and accompanying text.

327. Allen, *supra* note 326, at 274.

328. For example, acupuncture may be used for cocaine detoxification. *See id.* at 275.

329. *See id.*

330. Telephone Interview with Michael Harle, Director of Gaudenzia (Jan. 6, 1993). Many hospitals providing back-up care would have obstetrical and gynecological services available. However, it is important to note that not all hospitals offer such services. For example, some community-based facilities specialize in providing certain types of care, which may lead to the elimination of obstetrical and gynecological services. These institutions deny substance abuse treatment to pregnant women at their own facilities. *See, e.g., Hearing before Philadelphia Comm'n on Human Relations* (Jan. 10, 1994) (prepared

step if detoxification is not recommended, a patient enters a longer-term treatment program. Among pregnant women living in the inner city, treatment for cocaine addiction is most in demand.<sup>331</sup> "The prevailing model employed for the treatment of cocaine/crack addiction is a psychotherapeutic one."<sup>332</sup> Because treatment for cocaine addiction is drug-free, the care of pregnant women does not present particular treatment-related problems.<sup>333</sup> Pregnant cocaine-addicted women can be accommodated in the variety of drug-free programs without endangering their health or creating significant costs.<sup>334</sup>

Research shows that therapeutic communities<sup>335</sup> can be successful in treating women, and that addicted mothers may benefit from such programs.<sup>336</sup> While men and women show similar outcomes, women especially benefit because they usually enter with lower self-esteem. "Influenced by socially conditioned perceptions and value judgments concerning female role expectations, women accept (or internalize) the conventional view that their drug use is 'sicker' or more deviant than that of males. They express more depression, anxiety, and guilt in relation to their drug abuse than do men."<sup>337</sup> These drug-free environments can provide successful and healthy treatment for pregnant cocaine-addicted women. Concern about safely treating pregnant women will not justify excluding them from therapeutic communities.

In contrast to the drug-free treatment approach for cocaine addiction, treatment for heroin addicts generally involves the use of methadone.

statement of Joseph V. Pettinati, Vice President of Psychiatry and Substance Abuse Service, Mt. Sinai Hospital) (manuscript on file with the *Yale Journal of Law and Feminism*).

331. See Sandra McCalla et al., *The Biological and Social Consequences of Perinatal Cocaine Use in an Inner-city Population: Results of an Anonymous Cross-sectional Study*, 164 AM. J. OBSTETRICS & GYNECOLOGY 625 (1991). It is important to note, however, that many cocaine addicts engage in multiple drug abuse. See Sandra G. Boodman, *Treating Cocaine Addicts: Why It's So Tough*, WASH. POST, Nov. 28, 1989, at Z12. Therefore, while the following discussion addresses each addiction separately, in practice programs must combine approaches.

332. Chavkin, *supra* note 22, at 485.

333. Although the treatment approach itself does not differ, pregnant women will need prenatal care and other related services. These needs can be safely provided to most clients in treatment. See *infra* notes 347-54 and accompanying text.

334. Common methods of drug-free cocaine treatment include: twenty-eight-day inpatient rehabilitation programs, which provide detoxification and individual and group therapy; twelve-step programs, such as Narcotics Anonymous, which are so successful that they also are usually used as an ancillary part of any other type of treatment; therapeutic communities (TCs), which utilize a supportive but highly structured program to secure behavioral changes; and acupuncture, which many addicts say helps them relax and reduces their craving for cocaine. See Boodman, *supra* note 331, at Z12, Z14.

335. "TC programs are highly structured blends of resocialization, milieu therapy, behavioral modification practices, progression through a hierarchy of occupational training and responsibility within the TC, community reentry, and a variety of social services." TREATING DRUG PROBLEMS, *supra* note 6, at 14.

336. See George De Leon & Nancy Jainchill, *Residential Therapeutic Communities for Female Substance Abusers*, 67 BULL. N.Y. ACAD. MED. 277, 279-81 (1991). However, these studies looked primarily at heroine users, and recidivism generally is a greater problem among cocaine users than among heroin addicts because patients cannot be offered a substitute. See Louis G. Keith et al., *Drug Abuse in Pregnancy*, in DRUGS, ALCOHOL, PREGNANCY AND PARENTING 17, 43 (Ira J. Chasnoff ed., 1988) (noting study that demonstrated that only one-third of cocaine addicts were able to maintain a drug-free state).

337. De Leon & Jainchill, *supra* note 336, at 282.

Methadone was first used to treat heroin addiction in 1965 and was first tested on pregnant women in 1969.<sup>338</sup> In the early 1970's, the Food and Drug Administration suggested methadone maintenance for pregnant heroin-dependent women, but quickly withdrew that recommendation.<sup>339</sup> At the same time, the medical literature revealed some dangers to the fetus from methadone maintenance, warnings about the need for careful monitoring and debates about appropriate methadone dosages.<sup>340</sup>

The medical community has overcome somewhat its reluctance to prescribe methadone maintenance for pregnant heroin addicts as research has shown that maintenance at low levels during pregnancy does not adversely affect birth outcomes.<sup>341</sup> Because high dosages of methadone are associated with neonate mortality and morbidity, most clinicians prescribe a low daily dose of 20 mg or less.<sup>342</sup> At this low dosage level, "the neonate will have an easily treatable withdrawal syndrome, although many neonates of mothers maintained on such low doses frequently do not require any specific pharmacological treatment."<sup>343</sup> The only complication that may occur in the newborn from maternal methadone maintenance is temporary opiate withdrawal syndrome.<sup>344</sup> Therefore, pregnant heroin addicts can be safely treated in a manner similar to nonpregnant addicts, disallowing any targeted exclusion of pregnant women.<sup>345</sup>

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338. See Keith et al., *supra* note 336, at 39. In treating pregnant heroin-addicted women, the main goals are to avoid "cyclic craving" and sudden withdrawal. Methadone creates a stable environment for the fetus, decreases maternal complications and improves pregnancy outcomes. See *id.* at 41.

339. See Chavkin, *supra* note 22, at 485.

340. See *id.* In addition to the specific debate about methadone maintenance for pregnant women, the general use of methadone to treat heroin addiction remains somewhat controversial. Some have opposed methadone treatment because methadone itself is addictive. See JOHN KAPLAN, *THE HARDEST DRUG: HEROIN AND PUBLIC POLICY* 219 (1983). Supporters of methadone maintenance acknowledge its addictive quality but believe this should not automatically lead to its disqualification as a form of treatment. "The fact that methadone maintenance is not a cure for addiction should not be determinative so long as it improves the addict's life and health and lowers the cost he imposes on society." *Id.*

341. See *MANUAL OF DRUG & ALCOHOL ABUSE: GUIDELINES FOR TEACHING IN MEDICAL AND HEALTH INSTITUTIONS* 206-207 (Awni Arif & Joseph Westermeyer eds., 1988) [hereinafter *MANUAL OF DRUG & ALCOHOL ABUSE*]; Loretta P. Finnegan et al., *Narcotic Addiction in Pregnancy, in DRUG USE IN PREGNANCY* 163, 171 (Jennifer R. Niebyl ed., 1982); Keith et al., *supra* note 336, at 40, 42. Evidence exists showing pregnancy outcomes are better for women in methadone maintenance programs than for heroin or methadone addicts not in treatment. These outcomes are thought to reflect improved lifestyle and medical care as well as access to services associated with the maintenance programs. Chavkin, *supra* note 22, at 485.

342. See *MANUAL OF DRUG & ALCOHOL ABUSE*, *supra* note 341, at 206.

343. *Id.*

344. See Finnegan et al., *supra* note 58, at 230. Methadone detoxification, however, is not recommended for pregnant women. See *supra* note 326. Sudden withdrawal from heroin or methadone creates a significant risk of fetal death. See *MANUAL OF DRUG & ALCOHOL ABUSE*, *supra* note 341, at 206.

345. Such exclusions are especially problematic because methadone maintenance also should be used with caution when treating other types of clients, such as those with pre-existing respiratory disorders. See EDWARD R. BARNHART, *PHYSICIANS' DESK REFERENCE* 1927 (45th ed. 1991) (noting that overdosage of methadone may be characterized by respiratory depression, i.e. a decrease in the respiratory rate, thus the need for special caution in treating individuals with pre-existing respiratory conditions). Despite the similarity in treatment precautions, however, these other clients are not barred by the exclusionary policies that target pregnant women.

In addition to concerns regarding general treatment approaches,<sup>346</sup> ADAMHA defendants, particularly residential programs, also may claim that their blanket exclusions of pregnant women are justified due to the unavailability of on-site obstetrical care. A court should not sustain this claim. A treatment program can rely on off-site obstetrical care, just as other types of medical services are provided to clients with specific concerns.<sup>347</sup> Off-site obstetrical care does not present a danger to pregnant women in drug treatment.

If the pregnant woman has complications when she is at home, she either calls her doctor or goes to the emergency room or goes to the hospital. There is no reason to believe . . . [that] a residential program would not be able to handle that person in the exact same fashion as somebody who is at home or any other facility in the workplace. The facility would be able to call, make arrangements to have her provider notified, and then the patient could be evaluated in that program.<sup>348</sup>

As part of this analysis, it is important to note that the need for emergency services, for example due to premature labor, generally is eliminated when a pregnant woman stops using drugs.<sup>349</sup> Obstetrical care for pregnant women in drug treatment does not differ from that provided to other pregnant women.

Several clinics have demonstrated the feasibility of providing pregnant women with the care they need.<sup>350</sup> These programs underline the weaknesses of medical justifications for excluding pregnant women from drug treatment programs. For example, Gaudenzia in Philadelphia has admitted pregnant women since it opened its doors in 1968.<sup>351</sup> The program's director explained: "It is my professional opinion that there are no valid reasons for

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346. Another concern regarding the appropriateness of certain drug treatment programs for pregnant women focuses on the rigor of the treatment schedule. Such a concern does not justify exclusion of pregnant women. As one expert explained,

[Pregnant] women are able to carry on their lives when they are not drug dependent. They are allowed to work. They are allowed to shop. They are allowed to do everything that they do any other time. And there is no reason to think that the schedule that is required in a residential program or in an outpatient program would adversely affect that pregnancy. In fact, the fact that she is getting treatment for her drug addiction will impact positively on the pregnancy . . .

Statement of Dr. Arnold Cohen, *supra* note 32, at 142.

347. For example, Genesis II, a drug treatment program in Philadelphia that accepts pregnant women, utilizes off-site providers of prenatal care. Clients with medical coverage may select the provider of their choice; uninsured clients are sent to a free clinic. All pregnant clients enter prenatal care within their first week in the program. Clients with HIV, or other conditions identified in the initial physical examination, are presented with similar options for ancillary care. Telephone Interview with Shelita Swinton, Residential Coordinator, Genesis II (Mar. 10, 1994).

348. Statement of Dr. Arnold Cohen, *supra* note 32, at 148.

349. *Id.*

350. These clinics include: Pregnant Addicts-Addicted Mothers in New York City; the Eleanor Hutzel Hospital program in Detroit; and Center of Care in California. Kandall & Chavkin, *supra* note 93, at 642.

351. See Affidavit of Michael Harle, Director of Gaudenzia, in Letter from Women's Law Project to Philadelphia Commission on Human Relations, Exhibit B, ¶ 3 (Sept. 4, 1992) (seeking an investigation of pregnancy discrimination by substance abuse treatment programs in Philadelphia).



a qualified treatment program, with a well-trained staff, to deny access to pregnant women and such denial of access is largely based on ignorance and fear.”<sup>352</sup> He acknowledged that pregnant drug-addicted women are high-risk patients, but added that, “every drug addict is a high risk patient.”<sup>353</sup> Thus, it is important to “look at each individual . . . and not just turn down a woman because she is pregnant.”<sup>354</sup>

Individualized intake assessments of pregnant women are medically and fiscally possible. In fact, treatment programs that accept pregnant women generally require such examinations. These assessments enable a program to identify a woman’s ancillary obstetrical needs. They also ensure that an individual woman who could not be safely treated at a facility without on-site care would not be admitted. While there is the concern that a pregnant woman who could not be safely treated with only off-site obstetrical services may not be properly identified, individual evaluations should enable programs to identify problem cases in advance. Further, there are few, if any, instances when this would occur.<sup>355</sup>

Under the proposed standard, individual assessments would be required by ADAMHA as a reasonable alternative to blanket exclusions. Drug treatment programs that utilize blanket exclusions instead of individual assessments would be required to restructure their intake procedures. This standard may be more stringent than that put forth by the New York Court of Appeals in *Elaine W.* The *Elaine W.* court held that blanket exclusions were permissible where a defendant “cannot, prior to admission, identify with reasonable medical certainty those women who might receive treatment without needing immediate, on-site obstetrical services.”<sup>356</sup> The court does not elaborate on the meaning of “cannot.” The court’s standard may evaluate only a program’s present ability to make an individualized determination; it may not require a program to alter its procedures or enhance its resources in order to make such distinctions possible, as does the standard proposed by this Article.

The preceding analysis suggests that drug treatment for most pregnant women does not differ dramatically from programs for non-pregnant addicts. While pregnant clients require some services that nonpregnant clients do not, and some individual pregnant clients may require significant medical accommodations, substantial treatment modifications generally are not required. Further, the obstetrical needs of pregnant women throughout the period of drug treatment usually can be met through part-time services or arrangements with outside providers. In cases where these generalizations do not apply, individual assessments provide a targeted method of identifying clients who could not be

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352. *Id.* at ¶ 14.

353. Telephone Interview with Michael Harle, Director, Gaudenzia (Jan. 6, 1993).

354. *Id.*

355. Telephone Interview with Ruth Banks, Director, Women’s World Program, in Philadelphia, PA (Mar. 16, 1994).

356. *Elaine W. v. Joint Diseases N. Gen. Hosp., Inc.*, 613 N.E.2d 523, 525 (N.Y. 1993).

safely treated. Blanket exclusions are not necessary to satisfy the fundamental objectives of drug treatment programs. Medical justifications for excluding pregnant women from drug treatment, whether based on medical costs or fear of harming a woman or her fetus, will not stand up in court.

## 2. *Fear of Liability*

Fear of tort liability lies at the root of pregnancy discrimination by some drug treatment programs,<sup>357</sup> although it may be masked by more publicly acceptable medical justifications. While *Johnson Controls* seems to indicate that such fears would not be an acceptable defense to pregnancy discrimination,<sup>358</sup> the widespread nature of this concern warrants a brief discussion of the argument's merits.

Although treatment programs may fear liability for damage to the fetus, such fear is not well-founded. First, there is little chance that such suits would be brought. One study showed that state drug treatment officials did not believe that liability was "a legitimate concern" of treatment programs; government authorities did not find any increase in lawsuits or insurance costs connected with the treatment of pregnant drug-dependent women.<sup>359</sup> This finding likely is due to the fact that if a woman who used drugs during pregnancy brought such an action, she would face significant hurdles regarding the merits of her claim.<sup>360</sup>

Further, if a plaintiff (either the woman herself or the child) brought a tort action, the defendant's liability would be severely limited. As part of proving her *prima facie* case, the plaintiff initially would have to demonstrate that the defendant was a cause in fact and a proximate cause of the harm to her fetus.<sup>361</sup> Showing that a treatment provider caused fetal harm might be difficult due to proof problems created by the mother's use of drugs during her pregnancy.<sup>362</sup>

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357. See HUMAN RESOURCES DIVISION, UNITED STATES GENERAL ACCOUNTING OFFICE, GAO-HRD-91-80, ADMS BLOCK GRANT: WOMEN'S SET-ASIDE DOES NOT ASSURE DRUG TREATMENT FOR PREGNANT WOMEN 18 (1991) [hereinafter "HUMAN RESOURCES DIVISION, ADMS"].

358. See *supra* note 309 and accompanying text. The Court's reasoning, in fact, provides a possible defense to tort suits. See *infra* note 364 and accompanying text.

359. See HUMAN RESOURCES DIVISION, ADMS, *supra* note 357, at 18. These officials noted that invoking fear of liability "was more likely a justification that providers used for turning away pregnant women because the providers were unequipped to, or uninterested in, meeting the needs of these women." *Id.*

360. Telephone Interview with Susan Jacobs, Legal Action Center (Jan. 11, 1993). A group of medical malpractice lawyers in New York are working with plaintiffs' and defendants' attorneys to promote an understanding of why suits against clinics would not be productive. The group notes that such medical malpractice suits are problematic because the woman herself may be a weak plaintiff since she was using drugs during her pregnancy. *Id.* Also, in actions on behalf of the child, the mother could be joined as a defendant since she will not be able to claim parent-child immunity. J.D. LEE & BARRY A. LINDAHL, MODERN TORT LAW: LIABILITY & LITIGATION § 18.09 at 643-44 (1988).

361. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 41, at 269 (5th ed. 1984).

362. Telephone Interview with Susan Jacobs, Legal Action Center (Jan. 11, 1993).

If the plaintiff satisfied this requirement, however, she still would have to show that the treatment provider acted unreasonably according to the prevailing standards of the profession.<sup>363</sup> As long as a drug treatment program acts reasonably—receiving approval from a pregnant woman's prenatal care provider and advising the woman about what tasks she should not undertake—the risk of taking in a pregnant client would not differ significantly from that of treating any other client. Of course, a treatment provider could still be liable for negligent provision of services, but this is true whether or not pregnant women are accepted for drug treatment.

In response to a finding of negligence, a defendant would be able to raise an affirmative defense. Following *Johnson Controls*, a defendant could claim that the federal ADAMHA statute shields it from liability. As the *Johnson Controls* Court explained, compliance with a federal statute will generally absolve a party who acts reasonably from liability under conflicting state tort law.<sup>364</sup>

Fear of liability, then, is not a viable affirmative defense for discriminating against pregnant women in drug treatment programs. Such clients are unlikely to bring suits. Even if such suits were brought, defendants would only be liable for acting unreasonably where the plaintiff could demonstrate actual and proximate causation of the fetal harm in question. Defendants would also be able to avail themselves of an affirmative defense. Accordingly, liability does not threaten the fundamental objectives of providing safe treatment or financially maintaining a treatment program and therefore cannot justify discrimination.

### CONCLUSION

The ADAMHA Reorganization Act plays a vital role in addressing the current problem of drug addiction among pregnant women. The nondiscrimination provision offers particular assistance by allowing pregnant women access to the maximum number of facilities. Pregnant women may enforce their rights under the nondiscrimination provision itself and under § 1983, although the remedies will vary under each statute. Further, treatment programs will not be able to rely on medical justifications or fears of liability to uphold blanket exclusions of pregnant women. Lawsuits under ADAMHA's nondiscrimination provision are capable of opening up large numbers of federally funded treatment slots, offering some hope for pregnant drug-addicted women and their newborns.

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363. KEETON ET AL., *supra* note 361, at 187.

364. See *International Union, UAW v. Johnson Controls, Inc.*, 499 U.S. 187, 209 (1991) ("When it is impossible for an employer to comply with both state and federal requirements, this Court has ruled that federal law pre-empts that of the states.").

But ADAMHA does not offer treatment on demand. Nor does it eradicate the social factors often connected to drug addiction. ADAMHA's "anti-discrimination provision is [only] a device for telling legislatures, governments and designated others what they may not do, thus setting parameters within which they must operate. It does not, and cannot, do the basic job of readjusting the social order."<sup>365</sup>

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365. Williams, *supra* note 41, at 374.